STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

April 3, 2009

GENERAL LETTER NO. 6-AP-85

ISSUED BY: Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 6, ***INCOME MAINTENANCE PROGRAMS APPENDIX***, Contents (pages 1, 2, 4 through 7, 9, and 12), revised; pages 4, 4a, 4b, 4c, 13, 14, 29, 30, 32, 33, 34, 37, 38, 38a, 47 through 50, 104d, 123, 124, 125, 126, 136g, 154 through 164, 177, 178, 235, 253, 350, 410, 411, and 429, revised; pages 4d, 4e, 38b, and 86c, new; and the following forms:

470-4670	*Addendum to Application and Review Forms for Release of Information*, new
470-4670(S)	*Addendum to Application and Review Forms for Release of Information* (Spanish), new
427-0415(S)	*Agreement for Telephone Hearing* (Spanish), new
470-3144	*Attribution of Resources Appeal Summary*, revised
470-0461	*Authorization for Release of Information*, revised
470-0461(S)	*Authorization for Release of Information* (Spanish), revised
Comm. 305	*Basic Documentation for Child Care Assistance (CCA) Applications*, new
RC-0033	*Desk Aid*, revised
Comm. 306	*Eligibility Guidelines for Child Care Assistance (CCA)*, new
Comm. 2	*Facts About the Food Assistance Program*, revised
Comm. 3	*Facts About the Food Assistance Program* (Spanish), revised
470-2914	*Foster Care, Adoption, and Guardianship Medicaid Review*, revised
470-2914(S)	*Foster Care, Adoption, and Guardianship Medicaid Review* (Spanish), new
470-4537	*Important Information About Your Medicaid Benefits*, new
470-2826	*Insurance Questionnaire*, revised
470-2826(S)	*Insurance Questionnaire* (Spanish), revised
470-4542	*IowaCare Insurance Information Request*, new
470-2527	*MAC Income Worksheet*, revised
470-2588	*Notice of Attribution of Resources*, revised
470-3152	*Notice of Cancellation/Redetermination*, revised
470-0485	*Notice of Decision*, revised
470-0485(S)	*Notice of Decision* (Spanish), revised
470-0486	*Notice of Decision*, revised
470-0486(S)	*Notice of Decision* (Spanish), revised

470-0288(S)	*Notice of Disqualification* (Spanish), new
470-2960	*Reporting Food Assistance Changes*, revised
470-2960(S)	*Reporting Food Assistance Changes* (Spanish), revised
Comm. 258	*Verifying Citizenship and Identity*, revised
Comm. 258(S)	*Verifying Citizenship and Identity* (Spanish), revised

Summary

This chapter is revised to:

- Add form 470-4670, *Addendum to Application and Review Forms for Release of Information*, and its Spanish translation, 470-4670(S). This form is intended to streamline the process of getting verification for all income maintenance programs.
- Add the Spanish version of the following forms:
  - 427-0415(S), *Agreement for Telephone Hearing* (Spanish)
  - 470-0288(S), *Notice of Disqualification* (Spanish)
- Revise form 470-3144, *Attribution of Resources Appeal Summary*, to simplify the language to make it easier to read. The form automatically calculates the age of the spouse at home as of the date of the appeal. A drop-down box was added so workers could choose the appropriate minimum monthly maintenance needs allowance; however, the form will default to the current year's amount. A print button has been added.
- Update the following forms as they have been simplified so they are easier to read and understand:
  - 470-0461, *Authorization for Release of Information*
  - 470-0461(S), *Authorization for Release of Information* (Spanish)
- Add Comm. 305, *Basic Documentation for Child Care Assistance (CCA) Applications*, which provides general information about the documentation needed for Child Care Assistance applications.
- Remove obsolete forms 470-0321, *Change Report*, and 470-0322, *Change Report* (Spanish). All Food Assistance households are now subject to simplified reporting. Households report changes on form 470-2960 or 470-2960(S), *Reporting Food Assistance Changes*.
- Update the following forms to reflect the April 1, 2009, change in Food Assistance allotments due to the American Recovery and Reinvestment Act of 2009:
  - RC-0033, *Desk Aid*
  - Comm. 2, *Facts About the Food Assistance Program*
  - Comm. 3, *Facts About the Food Assistance Program* (Spanish)
- Update RC-0033, *Desk Aid*, and 470-2527, *MAC Income Worksheet*, to reflect the 2009 federal poverty guidelines.
- Add Comm. 306, *Eligibility Guidelines for Child Care Assistance (CCA)*, which provides general information about the Child Care Assistance program.

- Change the name of form 470-2914 from *Foster Care and Subsidized Adoption Medicaid Review*, to *Foster Care, Adoption, and Guardianship Medicaid Review,* to reflect that the form is also used for review of subsidized guardianship cases. The form has been added to both eForms and Outlook. A Spanish version of the form, 470-2914(S), is also now available.
- Add form 470-4537, *Important Information About Your Medicaid Benefits*. Form 470-4537 is issued from Central office two months before a member turns age 65 and when the Centers for Medicare and Medicaid Services notifies the Department that a member has Medicare benefits. Form 470-4537 notifies the member that Medicaid will stop paying for most prescriptions when the member is eligible for Medicare.
- Add form 470-4542, *IowaCare Insurance Information Request,* to request needed health insurance information from an IowaCare member. The Iowa Medicaid Enterprise sends reports when IowaCare members have health insurance. Members are to report within 10 days if they get health insurance. This is new information. The IM worker must confirm that the health insurance meets one of the exceptions for Iowa Care eligibility.
- Revise form 470-2588, *Notice of Attribution of Resources,* so the worker can enter both the date the attribution was processed and the effective date of attribution. Options have been added to indicate if this is an original or a revised attribution. Language is added to clarify the resources as of the first of the month. Additional lines have been added to the countable resources table. Language has been removed to make it easier for the applicant to read and understand the form.
- Update the appeal rights on form 470-3152, *Notice of Cancellation/Redetermination.*
- Update *Notice of Decision,* forms 470-0485, 470-0485(S), 470-0486, and 470-0486(S), to add language to review the entire notice. Manual forms 470-0486 and 470-0486(S) also have the updated TTY phone number for the U.S. Department of Agriculture. The number hasn't been updated on the system versions, 470-0485 and 470-0485(S), yet.
- Revise 470-2960 and 470-2960(S), *Reporting Food Assistance Changes,* to update reporting requirements. As a result of recent policy changes, child support is subtracted from the household's income before comparing it to the gross income limit. ABAWDs are not currently required to report if they stop working 80 or more hours in a month. In an effort to reduce Food Assistance errors, changes are also made to place more emphasis on reporting requirements.
- Change the name of form 470-2826 and 470-2826(S) from *Supplemental Insurance Questionnaire* to *Insurance Questionnaire.* The form has also been simplified so it is easier to read and understand.
- Remove page 2, *Birth Certificate Request by States*, from Comm. 258 and Comm. 258(S), *Verifying Citizenship and Identity*. This page provided phone and fax numbers for other states' vital records offices. Because these numbers are subject to change without notice, the *Birth Certificate Request by States* is being replaced with a web address that customers may use to find current contact information for other states' vital records offices.

Effective Date

April 1, 2009

Material Superseded

Remove the following pages from Employees' Manual, Title 6, Appendix, and destroy them:

Page	Date
Contents (page 1)	January 9, 2009
Contents (page 2)	January 30, 2009
Contents (page 4)	October 31, 2008
Contents (page 5)	January 30, 2009
Contents (page 6)	October 31, 2008
Contents (pages 7, 9, and 12)	January 9, 2009
4, 4a-4c *	January 9, 2009
13, 14	February 16, 2007
470-3144	4/06
29, 30, 32	February 1, 2008
470-0461	12/03
470-0461(S)	1/06
33	February 1, 2008
34	April 11, 2008
37, 38 *	February 1, 2008
38a *	June 27, 2008
46a *	March 12, 2002
46b *	October 19, 2007
46c *	February 1, 2008
47 *	July 15, 2005
48 *	February 1, 2008
470-0321	4/08
470-0322	4/08
49 *	February 1, 2008
50 *	January 30, 2009
RC-0033 (before p. 69)	3/09
Comm. 2 (after p. 104)	10/08
Comm. 3	10/08
104d	February 16, 2007
470-2914	6/07
123	June 27, 2008
124, 125	July 6, 2007
126	October 3, 2008
136g	January 9, 2009
154, 154a *	February 1, 2008
154b *	May 5, 2006
155 *	November 5, 2004

156 *	February 1, 2008
157, 158 *	November 5, 2004
163	February 16, 2007
164	July 15, 2005
177, 178	January 9, 2009
470-2527 (before p. 191)	4/08
470-2588	6/07
235	February 1, 2008
470-3152 (after p. 238)	7/94
470-0485 (after p. 238c)	1/08
470-0485(S)	1/08
470-0486	1/08
470-0486(S)	1/08
253	February 27, 2009
350	January 30, 2009
470-2960	2/09
470-2960(S)	2/09
410	May 5, 2006
470-2826	10/02
470-2826(S)	12/05
411	May 5, 2006
Comm. 258	5/08
Comm. 258(S)	5/08
429	February 1, 2008

* As forms are added and removed, existing pages are renumbered to eliminate or consolidate gaps. To accommodate these changes, the following form samples need to be refiled:

- Move form 470-4167 to follow page 4b instead of page 4.
- Move forms 470-3983 and 470-3983(S) to precede page 4c instead of page 4a.
- Move form 470-3774 to precede page 4e instead of page 4c.
- Move form 470-3775 to follow page 38 instead of preceding page 37.
- Move form 470-0130 to follow page 38b instead of preceding page 38a.
- Move form 470-3792 to precede page 47 instead of page 46a.
- Move form 470-3787 to follow page 48 instead of page 46b.
- Move forms 470-4487 and 470-4487(S) to precede page 49 instead of page 46c.
- Move form 470-1945 to follow page 50 instead of preceding page 47.
- Move Comm. 123 and Comm. 123(S) to precede page 155 instead of following page 154.
- Move Comm. 121 and Comm. 121(S) to follow page 156 instead of precede page 154a.
- Move form 470-3356 to precede page 157 instead of following page 154b.
- Move form 470-3779 to follow page 158 instead of preceding page 155.
- Move form 470-2815 to precede page 159 instead of following page 156.
- Move form 427-0292 to follow page 160 instead of preceding page 157.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Page

Page

Page

Page

Page

Page

Page

Page

Addendum to Application and Review Forms for Release of Information, Form 470-4670 or 470-4670(S)

Purpose	If signed, form 470-4670 or 470-4670(S) may be used to request information (other than protected health information) about any household member. The client is not required to sign this form.
Source	Print or photocopy the addendum from the samples in the manual or from the DHS Intranet eForms web page.
Completion	The client may use this form to authorize the Department to contact other people or organizations for information needed to determine eligibility and benefits without specific contacts with the client for each request. Instead of signing this form, the client may: ♦ Choose to provide necessary information, or ♦ Sign another form that is specific to the source and type of information, such as an *Employer's Statement of Earnings*. If the client chooses to use this form to authorize release of information: 1. Make entries in the Online Narrative to document the date this form was signed. 2. Use this form to request from other people or organizations any information that is needed to determine eligibility and benefits. 3. If the source of the information will not respond based on the client having signed this form, request the needed information from the client in writing. Help the client get information if the client asks for help.
Distribution	If the client signs form 470-4670 or 470-4670(S): ♦ Send a copy to other caseworkers that have an active file for the client. ♦ File the original or copy in the case file.

Iowa Department of Human Services

Addendum to Application and Review Forms for Release of Information

OPTIONAL Release of Information

Help Us Help You!

You do not have to sign this, but it will help us get information we need to help you, without having to get your signature on specific requests.

You should know that:

- We may need more information to decide if you can get assistance.
- If more information is needed from you, you will get a letter telling you what we need and the date you must get it to us.
- You are responsible to get the information or to ask us for help to get it.
- If you do not give us the information or ask for help by the due date, your application may be denied or your assistance may stop.
- We may be able to use the release below to get the information we need. **But you still have to provide information we request or ask us for help.**
- We may attach a copy of this release to a form that asks other people or organizations (like your employer) for specific information needed about you or others in your household.

Print and sign your name below to give us permission to get needed information.

RELEASE OF INFORMATION

I hereby authorize any person or organization to give the Iowa Department of Human Services requested information about me or other members of my household.

A copy of this release is as valid as the original.

This release does not apply to protected health information.

This release is good for 12 months from the date signed.

_____	_____
Your Name (please print clearly)	Other Adult Name (please print clearly)
_____	_____
Signature or Mark	Signature or Mark
_____	
Date	

Iowa Department of Human Services

Addendum to Application and Review Forms for Release of Information
(Adenda de los Formularios de Solicitud y Revisión para Divulgación de Información)

Divulgación de Información OPCIONAL

¡Ayúdenos a ayudarle!

No es obligatorio que firme esta autorización, pero nos ayudaría a obtener la información que necesitamos para ayudarle, y no tendríamos que pedirle que firme solicitudes específicas.

Debe saber que:

- Podríamos necesitar más información para decidir si puede obtener asistencia.
- Si necesitáramos que nos proporcione más información, recibirá una carta informándole qué necesitamos y la fecha en debe entregarla.
- Es su responsabilidad conseguir dicha información o pedirnos que le ayudemos a conseguirla.
- Si no nos proporciona dicha información ni nos pide ayuda antes de la fecha de entrega de la misma, su solicitud podría ser denegada o la asistencia podría terminar.
- Podríamos utilizar la siguiente autorización para obtener la información necesaria. **Pero aún así, deberá conseguir la información que le solicitemos o pedirnos ayuda para conseguirla.**
- Podríamos adjuntar una copia del mismo a otros formularios para solicitarles a otras personas u organizaciones (como, por ejemplo, su empleador) que nos proporcionen información específica sobre usted o los miembros de su grupo familiar.

Escriba su nombre en letra de imprenta y firme debajo para autorizarnos a obtener la información necesaria.

DIVULGACIÓN DE INFORMACIÓN

Por la presente autorizo a cualquier individuo u organización a entregar a Department of Human Services de Iowa la información solicitada sobre mi persona o mi grupo familiar.

Una copia de esta autorización es tan válida como el original.

Esta autorización no es válida en el caso de información protegida referida a la salud.

Esta autorización es válida por 12 meses a partir de la fecha de mi firma.

_____	_____
Su nombre (en imprenta legible)	Nombre de otro adulto (en imprenta legible)
_____	_____
Firma o marca	Firma o marca
_____	
Fecha	

This form is intended to collect information specified on a separate sheet. When using it to request information from other people or organizations in order to determine eligibility or benefits:

1. Fold form 470-4670 or 470-4670(S) in half and copy the "Release of Information" section of the form.

2. Fax or mail the copy to the source of information along with a form requesting specific information, such as form 470-2844, *Employer's Statement of Earnings,* or form 470-0461, *Authorization for Release of Information*.

When a signed release is in the file, requests for information may also be made by telephone.

Data

If the client chooses to use the form to authorize release of information, the client shall

- Print the client's name, and
- Sign and date the form.

Addendum to Application for Help with Medicare Prescription Drug Plan Costs, Form 470-4167

Purpose	Form 470-4167, *Addendum to Application for Help with Medicare Prescription Drug Plan Costs*, is used in conjunction with the Social Security Administration application entitled, *Application for Help with Medicare Prescription Drug Plan Costs*, form SSA-1020B-OCR-SM.
Source	Print or photocopy form 470-4167 from the manual or the DHS Intranet eForms web page.
Completion	When an applicant demands that DHS process the application for extra help with Medicare prescription drug plan costs instead of the Social Security Administration, the applicant must sign and date this form.
Distribution	File the addendum and the *Application for Help with Medicare Prescription Drug Plan Costs* in the case file.
Data	The form advises the applicant of terms for DHS process.

Adding an EBT Cardholder, Form 470-3983 or 470-3983(S)

Purpose	Form 470-3983, *Adding an EBT Cardholder*, is used by households who want a second Iowa EBT card for another member or for an authorized representative to use for shopping for the household. The form is also used as proof that the Department did not issue an additional Iowa EBT card on an account without permission of the household's primary cardholder. This form is not to be used for drug and alcohol treatment center or group living arrangement authorized representatives.
Source	Complete the English version of this form on line using the template on the DHS Intranet eForms web page. Print or photocopy the Spanish version of the form from the sample in the manual.
Completion	The form is completed by the IM worker, the Food Assistance head of household (the primary cardholder), and the secondary cardholder or authorized representative. The form must be fully completed and signed by all parties and returned to the DHS local office before a secondary cardholder or authorized representative can receive an Iowa EBT card on a Food Assistance household's EBT account.
Distribution	The Food Assistance household keeps the second copy when the form is given to the secondary cardholder or authorized representative. The secondary cardholder or the authorized representative keeps the third copy. File the completed original in the Food Assistance case record.
Data	**Case Information.** To be completed by the IM worker. **Case Name.** Enter the name of the primary cardholder (the ABC case name). **Case Number.** Enter the DHS Food Assistance case number.

Worker's Name. Enter name of the IM worker who is responsible for the Food Assistance case record.

Date. Enter the date the information is entered.

Adding an EBT Cardholder. These entries are completed by the primary cardholder (the ABC case name).

- **Name of Person You Want Added.** The primary cardholder enters the name of the person authorized as a secondary cardholder or authorized representative.
- **Your Signature.** The primary cardholder signs and dates the form.

New EBT Cardholder's Section. These entries are completed by the secondary cardholder or authorized representative.

- **Signature of New EBT Cardholder.** The person named by the primary cardholder signs to acknowledge agreement with the household.
- **Date.** The date of signature of the secondary cardholder or authorized representative.
- **Social Security Number.** The social security number of the secondary cardholder or authorized representative.
- **Birthday (mm/dd/yy).** Enter the birth date of the secondary cardholder or authorized representative.
- **Phone.** The phone number of the secondary cardholder or authorized representative.

Address Change, Form 470-3774

Purpose	Form 470-3774, *Address Change*, is used in conjunction with the Change Reporting System (CRS) to collect information for the Family Investment Program, the Food Assistance program, and the Medicaid program regarding a reported change of address.
Source	The CRS generates form 470-3774 in response to specific answers provided when completing an Address Change (ADD) incident screen narrative.
Completion	When a report is received that the household has moved, the CRS generates this form for the client to complete, if appropriate. The CRS populates certain areas of the form and calculates a due date for the return of the completed form.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record. The client completes the form and returns it to the local office. Enter information regarding the move on the ABC system.
Data	The form collects information about household composition and utility expenses.

Iowa Department of Inspections and Appeals

Agreement for Telephone Hearing
(Acuerdo para Audiencia Telefónica)

Llene este formulario antes de su audiencia para Violación Intencional de Programa (IPV) y devuélvalo a su oficina local del Department of Human Services (DHS).

Si tiene preguntas acerca de este formulario, por favor llame a la Sección de Apelaciones del DHS (Appeals Section) al (515) 281-8774.

Su sección

Lea, firme y feche la siguiente declaración:

Entiendo que tengo derecho a:

- Tener una audiencia personal, pero accedo, en cambio, a una audiencia telefónica
- Presentar mi caso
- Traer un abogado
- Mirar la evidencia
- Hacer preguntas a cualquier persona en la audiencia
- Entregar evidencia

Firma	Fecha

Sección del testigo

Soy testigo que la persona mencionada anteriormente leyó, firmó y fechó esta declaración.

Firma del testigo	Fecha

Sección del trabajador

Por favor llene las casillas siguientes y devuelva este formulario al Department of Inspections and Appeals Division of Administrative Hearings.

Número IPV	Número de caso

Agreement for Telephone Hearing, Form 427-0415 or 427-0415(S)

Purpose	Form 427-0415 is an agreement signed by the client to consent to a telephone hearing for an intentional program violation for the Food Assistance program.
Source	The Department of Inspections and Appeals sends this form to the local office with the *Notice of Hearing*.
Completion	The IM worker and the respondent complete this form before the telephone hearing.
Distribution	Keep the original in the client's case file in the local office. Return a copy to the Department of Inspections and Appeals.
Data	Sign and date the form and complete the appeal number and case number. Have the respondent sign and date the form in your presence.

Agreement to Pay a Debt, Form 470-0495

Purpose	Form 470-0495 is a written agreement between a debtor and the Department for repayment when a debt exists. This form is completed by the Department of Inspections and Appeals (DIA) and is included here for information only.
Source	Form 470-0495 is a three-part carbonized form issued by DIA.
Completion	The DIA investigator sends this agreement to a debtor to seek repayment for a debt owed to the Department of Human Services. The investigator may also send this form when demand letters have been sent four times for FIP, Medicaid, State Supplementary Assistance, Food Assistance claims, HIPP, ***hawk-i***, IowaCare, PROMISE JOBS, Refugee Cash Assistance or Child Care Assistance, and there has been no response. The debtor should return this form within 10 days. When a debtor fails to respond, other collection actions are pursued.
Distribution	DIA places the original in the Overpayment Recovery file and gives the copy to the debtor.
Data	The form states the amount of the debt and the repayment terms the debtor agrees to.

Iowa Department of Human Services

Attribution of Resources Appeal Summary

Appeal Number	Worker No.	County No.
Name of Spouse in Facility or Waiver		Birthdate
Name of Spouse at Home	Age on Date of Appeal	Birthdate
Date of Application for Attribution	Date of Application for Assistance	Date Appeal was Filed

☐ Date institutionalized spouse entered medical institution (includes hospital, nursing facility care, etc.), or date IFMC approves waiver:

☐ Date the waiver applicant met level of care criteria in a medical institution as established by the peer review organization:

Total of current combined resources (if different from attribution amount): $

A	2,739.00

A. Minimum monthly maintenance needs allowance as of the date of the appeal.

B. Community spouse gross income not derived from countable resources:

Social Security (gross)	
Employment (gross wages)	
Private Pension	
IPERS	
Other Income (specify):	

B	
C	
D	
E	

C. Available income from institutionalized spouse to community spouse if entered a facility or waiver on or after February 8, 2006. Should be zero if entered before February 8, 2006.

D. **Total monthly income (B + C)**

E. **Shortfall of income (A – D)**

At least one quote must be obtained from an insurance company for single-premium immediate lifetime annuities that will provide the community spouse a monthly payment equal to the shortfall of income from the minimum monthly maintenance needs allowance as of the date of the appeal. The bids shall be for life annuities with no remainder or term-certain payments.

AN ANNUITY DOES NOT NEED TO BE PURCHASED BY THE APPLICANT OR THE COMMUNITY SPOUSE. The annuity estimate is used to determine the amount of resources needed to provide the community spouse with an adequate monthly income.

ATTACHMENTS:

1. Application for attribution and application for assistance (if applicable).
2. Copy of the annuity bid.
3. Information regarding any questionable resources (if applicable).
4. Other evidence the parties wish to submit (if applicable).

Attribution of Resources Appeal Summary, Form 470-3144

Purpose	Form 470-3144 may be used as the Department's appeal summary when an appeal is filed to set aside additional resources for the community spouse.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes this form as an alternative to completing an appeal summary when an appeal is filed regarding the attribution of resources.
Distribution	Send one copy to the Department of Human Services, Appeals Section, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114. Keep a copy in the case record. Send a copy to the appellant.
Data	Enter the appeal number, if you know it, and your worker number and county number on the form. List: ♦ The names and birth dates of the institutionalized spouse and the community spouse. ♦ The date of the application for attributions. ♦ The date of the application for assistance. ♦ The date of appeal. ♦ The beginning date of continuous institutionalization or the date the waiver applicant met medical institution level of care criteria. ♦ The total amount of the couple's current resources, if different from the attribution amount. ♦ Select from the drop down box the minimum monthly maintenance needs allowance (MMMNA) as of the date the appeal was filed.

Verify and list the community spouse's available gross income. Calculate the shortfall between the community spouse's available gross income and the MMMNA. Attach all documents listed under the attachments listing.

For people who became institutionalized on or after February 8, 2006, include the income made available to the community spouse in the client participation calculation as available to the community spouse.

Authorization for Release of Information, Form 470-0461 or 470-0461(S)

Purpose	Form 470-0461 is designed to secure the client's permission for the Department to investigate items of eligibility or to obtain information needed for providing services. The source of information may also use the form to furnish the requested information.
Source	Complete the English or Spanish version of the form on line using the template on the DHS Intranet eForms web page.
Completion	Workers may complete this form when it is necessary to obtain information from a source other than the client. Complete a separate form for each source of required information. The worker completes the identifying information and the description of the information requested. The client (or the person authorized to obtain the information) signs that section to give the authorization. The source of information completes the remainder of the form. Additional pages may be used if necessary.
Distribution	Send one copy to the source of information with a self-addressed stamped envelope enclosed. Keep one copy as a control copy. When the source of information returns the original copy, destroy the control copy, and file the completed copy in the case record.
Data	To initiate the form, enter: ♦ Date ♦ Information due date ♦ The name and address of the source of information ♦ Your county ♦ Your worker number ♦ Your name ♦ Your phone number ♦ Your Email

Iowa Department of Human Services

Authorization for Release of Information

Date:

County:
Worker Number:
Worker Name:
Phone:

Information due date:

Email:

Dear

This form gives you permission to share information with the Department of Human Services (DHS).

Please fill out this form and send it back to me by:

- Mailing it in the enclosed postage paid return envelope,
- Bringing it to my office at:
- Faxing it to:

If you have any questions, please call me at the phone number above.

Information Requested

Please share this information with the Department of Human Services. I give my permission to the person or agency named above to share information about my family or me. I will not hold this person liable for giving information, even if it's confidential. This permission stops _____.

Name (please print)	Signature	Date

Please use the next page to provide a response to this request.

Response to Request

Signature of Person Sharing Information	Title
Phone Number	Date

Iowa Department of Human Services

Authorization for Release of Information
(Autorización Para Divulgación de Información)

Fecha:

Fecha de entrega de la información:

Condado:

Número del Asistente:

Nombre del Asistente:

Teléfono:

Email:

Estimado/a

Este formulario le autoriza a compartir información con Department of Human Services (DHS).

Por favor, llene este formulario y envíemelo:

- por correo en al sobre con franqueo pagado que se adjunta;
- o tráigalo a mi oficina sita en:

- por fax a:

Si desea hacer preguntas, por favor llámeme al teléfono indicado anteriormente.

Información Solicitada

Le agradeceré que comparta esta información con Department of Human Services. Doy mi permiso para que la persona u organismo mencionado anteriormente comparta información sobre mi familia o mi persona. Exonero a dicha persona de toda responsabilidad por entregar información, aún si la misma es confidencial. Este permiso expirará el _____ .

Nombre (en letra de imprenta)	Firma	Fecha

Por favor, utilice la página siguiente para responder esta solicitud.

Respuesta a la Solicitud

Firma de la Persona que Comparte Información	Título
Teléfono	Fecha

In the "Information Requested" section, enter the information the source will need to respond to the request. Be as specific as possible. Include the client's name, as well as the client's address or social security number, if they are needed to identify the requested information.

Enter the date the authorization expires. The expiration date shall be 60 days from the date the form is signed, unless you have supervisory approval to extend the date.

The client shall sign and date the form after these items have been completed.

The source of information completes the remainder of the form.

Authorization to Disclose Information to the Iowa Department of Human Services, Form 470-4459 or 470-4459(S)

Purpose

Form 470-4459 or 470-4459(S) is a two-way release form used to get the permission of the Medicaid applicant or the applicant's legally authorized representative to share health information needed to determine disability with the Disability Determination Services Bureau (DDSB).

Source

The English version of this form is available on line as a template on the DHS Intranet eForms web page.

The Spanish version may be printed or photocopied from the sample in the manual.

Completion

This form should be used only in conjunction with a referral to the DDSB for a disability determination. You may either:

- Send one original form to the applicant for completion and signature, and then make a photocopy of the original for each source and complete the name and address of the source of information in the "Additional information" box before sending the forms to DDSB; or
- Send the applicants one original 470-4459 for each source of information. The name and address of the source of information must be completed in the "Additional information" box before the form is sent to the DDSB.

You may complete the identifying information. The applicant or the applicant's personal representative signs the section to give the authorization. Obtain the signature of two witnesses for an applicant who cannot sign the form due to a physical or mental disability.

Discuss the authorization and the explanation on page 3 regarding the use of this form and answer any questions raised by the applicant. Explain the consequences of failure to sign the form.

Iowa Department of Human Services

Basic Documentation for Child Care Assistance (CCA) Applications

To help us determine your eligibility for Child Care Assistance as quickly as possible, please send proof of the following things along with your application (if you can). If you have questions or need assistance, please contact your local office.

Money From Work

Send proof of all money that everyone in the household made from working in the last 30 days. The kinds of proof you should send are:

- ☐ Pay stubs for the last 30 days.
- ☐ A statement from your employer showing gross pay and the hours you worked by pay date for the last 30 days.
- ☐ Sign a DHS form called the Employer's Statement of Earnings and have your employer complete it. (This is appropriate if pay stubs are not available, the employment is new, or your pay or number of hours worked has changed.)
- ☐ The most recent tax returns or business records of any self-employed person.

Other Money

Send proof of any money someone in the household gets from a source other than a job. Other money can come from:

- ☐ Unemployment benefits or worker's compensation
- ☐ Social Security or SSI
- ☐ Child support or alimony payments
- ☐ Veteran's or disability benefits
- ☐ Any other money you get from a source other than a job

School Schedule

If you are attending academic or vocational training on a full time basis, you must provide your:

- ☐ Official current class schedule

Basic Documentation for Child Care Assistance (CCA) Applications, Comm. 305

Purpose	Comm. 305, *Basic Documentation for Child Care Assistance (CCA) Applications*, provides general information about the documentation needed for Child Care Assistance applications.
Source	Comm. 305 can be printed or photocopied from the sample in the manual or printed from the DHS Intranet eForms web page.
Completion	The use of Comm. 305 is optional. No completion is required.
Distribution	At local option, mail or give the brochure to the applicant with the *Child Care Assistance Application*.

Beginning Employment, Form 470-3775

Purpose	Form 470-3775, *Beginning Employment*, is used in conjunction with the Change Reporting System (CRS) to collect information for the Family Investment Program, food stamp program, and Medicaid program. This form notifies the client of the information and verification needed to determine continued eligibility when it is reported that someone in the household has gone to work. This form is also used as a cover letter for the *Employer's Statement of Earnings*, form 470-2844, which the household may use to provide the needed information or verification.
Source	The CRS generates form 470-3775 in response to specific answers provided when completing a Beginning Employment (BEMP) incident screen narrative.
Completion	When it is reported that someone in the house has gone to work, CRS generates this form to request information and verification regarding the new income and to forward the *Employer's Statement of Earnings* form. The CRS populates certain areas of the form and calculates a due date for the return of the requested information.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The letter specifies what information is needed and the due date for returning it.

Beginning Income (BINC) Match, Form 470-3811

Purpose	Form 470-3811, *Beginning Income (BINC) Match*, is a cover letter used in conjunction with the Change Reporting System (CRS) to collect information for the Family Investment Program, Food Assistance program, and Medicaid program. This form forwards the *Employer's Statement of Earnings*, form 470-2844, which the household may use to provide the needed information and verification when a Beginning Income (BINC) screen identifies that someone in the household has gone to work.
Source	The CRS generates form 470-3811 in response to specific answers provided when completing a Beginning Employment (BEMP) incident screen narrative.
Completion	When a BINC screen identifies that someone in the household has gone to work and the worker completes the BEMP narrative, the CRS generates this form to forward the *Employer's Statement of Earnings* form. The CRS populates certain areas of the form and calculates a due date for the return of the requested information.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The form includes the information received from BINC and gives space for the client's explanation.

Billing Statement, Form 470-0130

Purpose	The *Billing Statement* is sent to debtors who have received a demand letter requesting repayment of a debt. It notifies debtors of payments due and account balances. It also shows account activity including all payments or adjustments applied to an account.
Source	Form 470-0130 is generated by the Overpayment Recovery System.
Completion	This form is generated: ♦ Monthly to debtors with a cash agreement, reflecting all payments received during the month. ♦ Quarterly to debtors on grant or benefit reduction. ♦ Periodically to debtors who have not completed a repayment agreement. The statements are printed on the last working day of each month.
Distribution	The form is mailed to the debtor.
Data	Debtors making cash payments detach the top of the statement and return it with the payment to the Department of Human Services, Cashier's Office, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

Change in Health Insurance, Form 470-3792

Purpose	Form 470-3792, *Change in Health Insurance*, is a cover letter used in conjunction with the Change Reporting System (CRS) to collect information for the food stamp and Medicaid programs. This form forwards the *Employer's Statement of Earnings*, form 470-2844, or the *Insurance Questionnaire*, form 470-2826 or 470-2826(S), which the household may use to provide the needed information or verification when a change in health insurance coverage is reported.
Source	The CRS generates form 470-3792 in response to specific answers provided when completing a *Beginning Employment* (BEMP) incident screen narrative.
Completion	When a BINC screen identifies that someone in the household has gone to work and the worker completes the BEMP narrative, the CRS generates this form to request information and verification regarding the new income and forward the *Employer's Statement of Earnings* form.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The CRS populates address and worker information areas of the form and calculates a due date for the return of the requested information.

Change in Housing or Utility Costs, Form 470-3787

Purpose	Form 470-3787, Change in Housing or Utility Costs, is both a form for gathering housing and utility change information and a cover letter used in conjunction with the Change Reporting System (CRS) to collect information for the Food Assistance program. This form notifies the household of the information or verification needed and forwards form 470-3786, *Shared Housing or Utility Costs*, as needed, when the household reports a change in housing or utility costs.
Source	The CRS generates form 470-3787 in response to specific answers provided when completing a Change in Housing or Utilities (SHEL) incident screen narrative.
Completion	When a household reports a change in housing and utility expenses, the CRS generates this form to forward the *Shared Housing or Utility Costs* forms, as needed.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The CRS populates address and worker information areas of the form and calculates a due date for the return of the requested information. The client completes information about housing and utility costs.

Change in Medical Deduction for Food Assistance, Form 470-4487 or 470-4487(S)

Purpose

Form 470-4487, *Change in Medical Deduction for Food Assistance*, is used in conjunction with a "warnings, informational, fatal, and summary" (WIFS) message when buy-in occurs for a Food Assistance household receiving the standard medical deduction.

Since the state is now paying the Medicare premium, the worker uses this form to determine if the person has other medical expenses that would qualify the household for the standard medical deduction.

Source

Complete the English or Spanish version of this form on line using the templates on the DHS Intranet eForms web page.

Completion

An informational WIFS message will be sent to the worker associated with a Food Assistance case when:

- Buy-in of the Medicare premium occurs for any individual active on the case, and
- The case is coded on BCW1 for the standard medical deduction for Food Assistance.

When a WIFS message is received, examine the case record to see if the household has any other verified medical expenses that qualify it for the Food Assistance standard medical deduction.

If not, remove the coding for the standard from the BCW1 and send this form.

Distribution

Print two copies of the completed form. Send one copy to the household and file one copy in the case record.

Data

The worker completes the date, address, case number, client name, and worker phone number and name. No due date is necessary, as this form is informational to the household and the household needs respond only if it has additional expenses to report.

Change of Primary Providers, Form 470-1945

Purpose	The purpose of form 470-1945 is to serve as documentation when a Medicaid member on lock-in wishes to change primary providers. The Division of Medical Services determines whether the request will be approved, with the assistance of the IME Medical Services Unit.
Source	Print form from the on-line manual or photocopy from sample in the printed manual.
Completion	The IM worker prepares this form when a lock-in member requests to change or add primary providers.
Distribution	Give or mail a copy to the member. File a copy in the case record. Send a copy to the Bureau of Managed Care and Clinical Services in the Division of Medical Services.
Data	Complete the "old provider" sections from information on form 470-1507, *Notice of Member Lock-In*. Complete the "new provider" sections with information furnished by the member.

Iowa Department of Human Services

DESK AID

COVERAGE GROUP	RESOURCE LIMIT	MONTHLY INCOME LIMITS							
Food Assistance	$3,000 if one or more age 60 or older or disabled $2,000 all other HH	Household Size	1	2	3	4	5	6	7
		Gross	$ 1,127	$ 1,517	$ 1,907	$ 2,297	$ 2,687	$ 3,077	$ 3,467
		Net	$ 867	$ 1,167	$ 1,467	$ 1,767	$ 2,067	$ 2,367	$ 2,667
		Max Allotment	$ 200	$ 367	$ 526	$ 668	$ 793	$ 952	$ 1,052
FIP	$2,000 per applicant HH $5,000 per recipient HH	Household Size	1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
FMAP and FMAP-Related Medicaid	$2,000 per applicant HH $5,000 per recipient HH	Household Size	1	2	3	4	5	6	7
		Test 1	$ 675.25	$1,330.15	$1,570.65	$1,824.10	$2,020.20	$2,249.60	$2,469.75
		Test 2	$ 365	$ 719	$ 849	$ 986	$ 1,092	$ 1,216	$ 1,335
		Test 3	$ 183	$ 361	$ 426	$ 495	$ 548	$ 610	$ 670
Mothers and Children (MAC) Medicaid *	$10,000 per HH	Household Size							
		Poverty Level	1	2	3	4	5	6	7
		200% Pg women/infants	$ 1,805	$ 2,429	$ 3,052	$ 3,675	$ 4,299	$ 4,922	$ 5,545
		For each additional household member add $624.							
		133% Children 1-18	$ 1,201	$ 1,615	$ 2,030	$ 2,444	$ 2,859	$ 3,273	$ 3,688
		For each additional household member add $415.							
Medically Needy Medicaid *	$10,000 per HH	Medically Needy Income Level (MNIL) by Household Size							
		1	2	3	4	5	6	7	
		$ 483	$ 483	$ 566	$ 666	$ 733	$ 816	$ 891	

	1	2	3	4	5	6	7
100% Poverty Level	$ 903	$ 1,215	$ 1,526	$ 1,838	$ 2,150	$ 2,461	$ 2,773
	For each additional household member add $312.						

	1	2	3	4	5	6	7
200% Poverty Level FIP Diversion	$ 1,805	$ 2,429	$ 3,052	$ 3,675	$ 4,299	$ 4,922	$ 5,545
	For each additional household member add $624.						

	1	2	3	4	5	6	7
300% Poverty Level MKSN	$ 2,708	$ 3,643	$ 4,578	$ 5,513	$ 6,448	$ 7,383	$ 8,318
	For each additional household member add $935.						

SSI-Related Medicaid *	$2,000 for 1 $3,000 for a couple	Household Size (Couple in own home) 1: $ 674 — 2: $ 1,011
Medically Needy Medicaid *	$10,000 per HH	Medically Needy Income Level (MNIL) Household Size 1: $ 483 — 2: $ 483 — 3: $ 566 — 4: $ 666 — 5: $ 733 — 6: $ 816 — 7: $ 891
QMB * (A Medicare Savings Program)	$4,000 for 1 $6,000 for a couple	Effective 3/1/09: Poverty Level 100% — Household Size: Individual $ 903, Couple $ 1,215
SLMB * (A Medicare Savings Program)	$4,000 for 1 $6,000 for a couple	Effective 3/1/09 / Over 100% but less than 120%: Individual — Income Over $ 903 — But Less Than $ 1,083; Couple — Income Over $ 1,215 — But Less Than $ 1,457
Expanded SLMB * (QI-1) (A Medicare Savings Program)	$4,000 for 1 $6,000 for 2	Effective 3/1/09 / 120% but less than 135%: Individual — Income $ 1,083 — But Less Than $ 1,219; Couple — Income $ 1,457 — But Less Than $ 1,640
QDWP Medicaid * (A Medicare Savings Program)	$4,000 for 1 $6,000 for a couple	Effective 3/1/09: Poverty Level 200% — Household Size: Individual $ 1,805, Couple $ 2,429
MEPD Medicaid for Employed People with Disabilities	$12,000 for 1 $13,000 for 2	Net countable income is less than 250% FPL MEPD Income Limit Household Size 1: $ 2,257 — 2: $ 3,036 — 3: $ 3,815 — 4: $ 4,594 — 5: $ 5,373 — 6: $ 6,153 — 7: $ 6,932 — 8: $ 7,711

Monthly Medicare Part B Premium
(Effective 1-1-2008)

$96.40

* Note: Compare net countable income to the income limits.

Medicaid for Employed People With Disabilities (MEPD)

	MONTHLY INCOME LIMITS						
	MEPD Household Size						
	1	2	3	4	5	6	7
Below 250% FPL	$ 2,257	$ 3,036	$ 3,815	$ 4,594	$ 5,373	$ 6,153	$ 6,932

2008 MEPD Premiums Effective July 1, 2008

If the gross monthly income of the person getting MEPD is:	FPL	Premium Amount
$ 1,354 or less	At or below 150%	**$ 0**
Above: $ 1,354	**Above:** 150%	$ 29
1,625	180%	53
1,986	220%	80
2,166	240%	110
2,365	262%	140
2,870	318%	170
3,087	342%	200
3,520	390%	230
3,836	425%	260
4,152	460%	291
4,513	500%	323
4,946	548%	354
5,479	607%	392
6,011	666%	430
6,544	725%	471
$ 7,437 and above	824%	535

IowaCare

	MONTHLY INCOME LIMITS						
	IowaCare Household Size						
	1	2	3	4	5	6	7
At or below 200% FPL	$ 1,805	$ 2,429	$ 3,052	$ 3,675	$ 4,299	$ 4,922	$ 5,545
Below 300% FPL	$ 2,708	$ 3,643	$ 4,578	$ 5,513	$ 6,448	$ 7,383	$ 8,318

2009 IowaCare Premiums

When the household's monthly income is at or below:	FPL	Each member's monthly premium is:
$ 903	100%	No cost
993	110%	$ 45
1,083	120%	49
1,174	130%	54
1,264	140%	58
1,354	150%	63
1,444	160%	67
1,535	170%	72
1,625	180%	76
1,715	190%	81
1,805	200%	85

Eligibility Guidelines for Child Care Assistance (CCA)

Child Care Assistance (CCA) is a program that can help income eligible families with the cost of child care. Families may apply for CCA by submitting a Child Care Assistance Application or a Health and Financial Support Application to their local county DHS office.

Age Requirements

- Children must be under age 13, or
- Age 13 up to age 19, if the child has special needs (documentation of the special need must be provided), or
- Age 13 up to age 16 if there are special family circumstances that put the safety and well being of the child at risk if left home alone (the parent or guardian must apply for an exception to policy).

Citizenship/Alien Status

Children must be United States citizens or have a qualifying alien status to be eligible for CCA.

Need for Service

The family must have a need for service to be eligible for CCA. All parents in the household must meet at least one of the need requirements. Need for child care service includes:

- Full time, as defined by the school, academic or vocational training (limited to 24 fiscal months)
- Employed 28 or more hours per week
- Protective child care, when the child has a case plan that identifies protective child care as a required service
- Medical absence or incapacity (temporary)
- Seeking employment (limited to one 30-consecutive-day period in any 12-month period)
- FIP recipient participating in PROMISE JOBS activities

Income Guidelines

Both earned and unearned income is used to determine eligibility. Families applying for child care who are on FIP or because of a protective need do not have to meet the income guidelines, but must have a need for service.

Gross (before taxes) monthly income limits

Family Size	Basic Care	Special Needs
1 member	$1,234	$1,702
2 members	$1,655	$2,282
3 members	$2,075	$2,862
4 members	$2,496	$3,442
5 members	$2,916	$4,022
6 members	$3,337	$4,602
7 members	$3,757	$5,182

Information Needed to Process Your Application

You must provide the Department with information to determine if you are eligible for CCA. If possible, supply this information with your application.

- If you are working, you must provide proof of your income from the past 30 days, such as pay stubs, a statement from your employer listing your gross wages and the hours you work or your employer completing a DHS form called the Employer's Statement of Earnings. If you are self-employed, you must provide your tax return or self-employment records including income and expenses.
- If you are attending academic or vocational training on a full time basis, you must provide your class schedule.
- If your household receives any other money, you must provide proof of the amount. Other money includes unemployment benefits, SSI, Social Security, child support, veterans benefits or any other money you receive from a source outside of a job.

Co-Pay

A family may be responsible for paying for part of their child care costs. This is called a co-pay. The family's co-pay is based on family size, gross income, and the number of children in care. The family is responsible to pay the co-pay directly to the provider. Families receiving child care because they are FIP recipients or because of protective needs do not have a co-pay.

Eligibility Determinations

The Department will process your application as soon as possible, but no later than 30 days from the date you apply for child care. We will notify you regarding your eligibility in writing with a Notice of Decision (NOD). This will tell you what children are approved for CCA, the start date and end date of assistance, the number of units approved, and your family's co-pay amount.

The Department must review every family's eligibility for CCA at least every six months. We will send you a review form with a due date on it. You must complete the review process for us to determine if you are eligible to keep getting CCA. If you do not return the review form by the due date, your CCA will end on the date given on your original NOD. If you return the review form along with all needed information, you will receive a new NOD regarding your eligibility.

Changes

You must tell your worker about the following changes within 10 days of the change:

- Work hours
- Class schedule
- Income
- Address change
- A change in who lives in your home
- Change in child care provider

Provider Requirements

You may choose any type of child care provider you wish. However, the provider you choose must be approved by DHS before payments can be made. To be "approved" the provider must be:

- A licensed center, or
- A registered child development home, or
- A nonregistered child care home who has certified that they meet minimum health and safety requirements and has passed the required criminal background and abuse checks.

You must have at least three children eligible for CCA to have a provider care for your children in your home.

All providers must sign a CCA Provider Agreement before payment can be made to them on behalf of eligible children. This agreement outlines the terms and conditions for the CCA program and certifies the reimbursement rates DHS will pay.

If you use a child care provider before they have been determined to be an eligible provider and they do not get approved as a provider, you will have to pay the provider yourself.

Provider Notification

If your family is eligible for CCA, your provider will receive a copy of your NOD. This will tell the provider what children are approved for CCA, the start date and end date of assistance, the number of units approved, and your family's co-pay amount. If you use a child care provider before you are eligible for CCA, you will have to pay the provider yourself.

The provider will not get any additional notification that your eligibility period is ending when it is time for your review. If you return the review form along with all needed information, your provider will receive a new NOD regarding your eligibility.

Eligibility Guidelines for Child Care Assistance (CCA), Comm. 306

Purpose	Comm. 306, *Eligibility Guidelines for Child Care Assistance (CCA) Applications*, provides general information about the Child Care Assistance program.
Source	Comm. 306 can be printed or photocopied from the sample in the manual or printed from the DHS Intranet eForms web page.
Completion	The use of Comm. 305 is optional. No completion is required.
Distribution	At local option, mail or give the brochure to the applicant with the *Child Care Assistance Application*.

Facts About the Food Assistance Program

INCOME GUIDELINES

The combined monthly income of a household must be below established maximums for gross monthly income and net monthly income for the household's size.

Maximum Gross Monthly Income Chart

Household Size	1	2	3	4	5	6	7	8	Each Additional Person
Gross Monthly Maximum	$1,127	$1,517	$1,907	$2,297	$2,687	$3,077	$3,467	$3,857	+$390

Gross monthly income includes all money (before taxes and other deductions) coming into the household. To be eligible for Food Assistance, a household must have income below the maximum gross monthly income. There are two exceptions:

- Households with at least one member who is over age 59 or disabled.
- Households in which all members get SSI or Family Investment Program (FIP).

These households may have more gross monthly income than the amounts above.

Maximum Net Monthly Income Chart

Household Size	1	2	3	4	5	6	7	8	Each Additional Person
Net Monthly Maximum	$867	$1,167	$1,467	$1,767	$2,067	$2,367	$2,667	$2,967	+$300

Net monthly income is what is left of the household's gross income after certain allowable expenses are subtracted. All households must have net monthly incomes below the maximum net monthly income to receive Food Assistance. Households with one or two members may have net income more than the maximum if all members get SSI or FIP.

MAXIMUM FOOD ASSISTANCE ALLOTMENT

Households are eligible for different amounts of Food Assistance. A household's Food Assistance amount depends upon the household's size and income. Only households with very little or no monthly income receive the maximum amount.

Household Size	1	2	3	4	5	6	7	8	Each Additional Person
Dollar Amount	$200	$367	$526	$668	$793	$952	$1,052	$1,202	+$150

WHERE TO APPLY

If you want to apply for Food Assistance you can apply online at www.yesfood.iowa.gov. You can also apply at the Human Services office. The address and phone number of the Human Services office is in the county government listing of your telephone book under the heading "Human Services." (A few counties have the listing under "Social Services.")

Iowa Department of Human Services

Facts About the Food Assistance Program
(Informacion Respecto al Programa de Food Assistance)

GUÍA DE INGRESOS

El total de ingresos mensuales de la familia que tiene que ser menos que el máximo establecido de Ingresos Brutos Mensuales e Ingresos Netos Mensuales para el tamaño de la familia.

Lista de los Máximos Ingresos Brutos Mensuales

Número por Familia	1	2	3	4	5	6	7	8	Cada Persona Adicional
Máximos de Ingresos Brutos Mensuales	$1,127	$1,517	$1,907	$2,297	$2,687	$3,077	$3,467	$3,857	+$390

Ingresos Brutos Mensuales consisten en todo el dinero que recibe una familia. Para ser elegible de recibir food assistance la familia no puede contar con mas del máximo correspondiente de Ingresos Brutos Mensuales. Hay dos excepciones:

- Una familia con por lo menos un miembro quien es anciano o incapacitado.
- Una familia en la cual todos los miembros reciben SSI o FIP.

Estas familias pueden contar con mas Ingresos Brutos Mensuales que el máximo establecido.

Lista de los Máximos de Ingresos Netos Mensuales

Número por Familia	1	2	3	4	5	6	7	8	Cada Persona Adicional
Máximos de Ingresos Brutos Mensuales	$867	$1,167	$1,467	$1,767	$2,067	$2,367	$2,667	$2,967	+$300

Los Ingresos Netos Mensuales quiere decir lo que queda de los Ingresos Brutos de una familia después de quitar ciertos gastos permitidos. Para recibir food assistance, es necesario que una familia tenga Ingresos Mensuales menos del Máximo de Ingresos Netos Mensuales con excepción de familias con uno o dos miembros nada mas pueden tener ingresos netos superiores al máximo establecido si todos los miembros reciben SSI o FIP.

RACIÓN MÁXIMA DE FOOD ASSISTANCE

No todas las familias son elegibles para la misma cantidad de food assistance. La ración de food assistance de una familia depende del tamaño de la familia y de sus ingresos. La ración máxima se les da solamente a las familias con muy pocos ingresos o las que carecen de ellos.

Número por Familia	1	2	3	4	5	6	7	8	Cada Persona Adicional
Cantidad en Dólares	$200	$367	$526	$668	$793	$952	$1,052	$1,202	+$150

DONDE HACER SU SOLICITUD

Si desea solicitor Food Assistance haga la solicitud en linea en www.yesfood.iowa.gov. También puede solicitarlo en la Oficina de Human Services (Servicios Humanos). La dirección y el número de teléfono de su oficina local de Human Services se pueden encontrar en el directorio telefónico en la sección de dedicada al gobierno del condado, bajo el titulo “Human Services,” ciertos condados lo anotan bajo el titulo de “Social Services.”

CSU: The worker number for the child support recovery officer.

VENDOR NO: The facility vendor number (if any).

PRIORITY INFORMATION: Free-form entries made by the IM worker.

The field to the right of the "Priority Information" field may contain codes identifying special characteristics of the case, such as:

- Presumptive eligibility FIP. (See 14-B-Appendix, TD02 PE.)
- Restrictions on Medicaid coverage to certain services or providers.
- Type of Food Assistance household. (See 14-B-Appendix, TD02 FSI.)

PERS NO: The "person number." (See 14-B-Appendix, TD03 PER.)

FIRST NAME, LAST NAME, SEX, BIRTHDATE: Self-explanatory.

S.I.D. NO: The client's state identification number.

MAR: Marital status. (See 14-B-Appendix, TD03 MAR.)

ETH: Ethnic origin. (See 14-B-Appendix, TD03 H W B A I N.)

EDUC: Education code (for FIP adults only). (See 14-B-Appendix, TD03 EDU.)

CD: Fund code, indicating the source of funding for Medicaid. (See 14-B-Appendix, TD03 FUND.)

FUND: Effective date of the fund code.

INC: Income code. ("Y" indicates the client has income; "N" indicates no income.)

SOC SEC NO: The client's social security number.

FOSTER CARE, ADOPTION, AND GUARDIANSHIP MEDICAID REVIEW

RETURN THIS FORM TO RECEIVE CONTINUOUS COVERAGE

INSTRUCTIONS FOR COMPLETION OF THE REVIEW FORM

This review form is sent to you to fulfill a requirement of the Medicaid program. It is important to complete the form and return it before the date on the form. The form must be signed by the adoptive parent, legal guardian, or by the child in supervised apartment living as the situation applies. An income maintenance worker in the Department of Human Services may contact you. In order to process your review, the income maintenance worker may request further verification or necessary information; including information about persons who will help to pay for the medical care.

Failure to return the form and cooperate in the review process can cause interruption of medical payments. Therefore, we ask your assistance in the review. If you have questions, please contact your service worker.

SPECIFIC INSTRUCTIONS

Foster/Adopted/Subsidized Guardianship Child and Siblings in Same Placement: List the child being reviewed and all of the child's siblings that are in the same placement. Do not list siblings living in other places. Only one review form is needed for the sibling group.

Student Status: Check if the child is a full-time or part-time student.

School and Grade: Enter the name of the school and the grade of the child and siblings in placement.

Name and Address of Employer: Enter the name and address of the employer of each child under review. If not employed, enter "N/A." Verification of the child's earned income is required for the whole calendar month.

Income: Enter all the unearned income that the children are eligible for or receiving. This means all unearned income that may be assigned to the Department and income from relatives, as well as income that the children receive from the sources listed. Write in the amount if known; otherwise check each item they are eligible for or receiving. (Unearned income is Social Security benefits or interest for example.)

Resources of Foster/Adopted/Subsidized Guardianship Child and Siblings Listed: Enter the type of resource and location of resources that the child owns. If there are no resources, enter "no."

Vehicles: Enter whether the child owns a vehicle and, if so, enter information about the vehicle.

Health Insurance for Child and Siblings Listed: Enter whether the child or siblings in the same placement have health insurance. Also enter the policy holder and company name. Where possible provide the policy number. Parents will receive a more extensive form to complete if the policy has changed.

Address of Parents: Enter the name and address of the natural mother and father for foster children and children in subsidized guardianship and the name and address of the adoptive child's adoptive parents. If the siblings of foster or subsidized guardianship children have different parents, identify the child with the parent.

IV-E Information: For foster care children in supervised apartment living, enter "yes" or "no" to the question about finishing school by age 19. **The whole section is to be completed for foster children in family homes and day care.**

Expected Changes: Report any changes that are expected to take place in the child's future, particularly within the next six months. This could include expected changes on any of the items listed on this form. Also include if the child is pregnant.

Signature and Date: The child in supervised apartment living, adoptive parent, or legal guardian for subsidized guardianships is expected to sign this form indicating that the information is true, correct, and complete.

Iowa Department of Human Services

Foster Care, Adoption, and Guardianship Medicaid Review

			Review Month	Due Date
Social Worker	County No.	IABC Case No.	Medical Review Worker	

Foster/Adopted/Subsidized Guardianship Child and Siblings in Same Placement
If more room is needed, attach a separate sheet.

	Child	Sibling 1	Sibling 2	Sibling 3
Child's Name				
State ID No.				
Is this child a student?	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time
School Name and Child's Grade				

Income. Child's income only.

Is this child employed?	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time	If yes: ☐ Full time ☐ Part time
Name and Address of Employer (attach verification of				
Social Security Benefit	$	$	$	$
SSI	$	$	$	$
Child Support	$	$	$	$
Military Allotment	$	$	$	$
Relatives/Friends	$	$	$	$
Interest Income	$	$	$	$
Other Income	$	$	$	$

Resources of Foster/Adopted/Subsidized Guardianship Child and Siblings Listed
If more room is needed, attach a separate sheet.

	Amount	Location	Name or Names of Person Owning
Checking Account ☐ Yes ☐ No			
Savings ☐ Yes ☐ No			
Stocks or Bonds ☐ Yes ☐ No			
Trust Fund ☐ Yes ☐ No			
Escrow Account ☐ Yes ☐ No			
Other ☐ Yes ☐ No			

	Make/Year	Market Value	Amount Owed	In Whose Name?
Automobile ☐ Yes ☐ No				
Truck/Motorcycle ☐ Yes ☐ No				

Health Insurance for Child and Siblings Listed ☐ Yes ☐ No

List Persons Covered	Policy Holder	Policy No.	Insurance Company Name

List child/children's names:	Name – Child	Name – Sibling 1	Name – Sibling 2	Name – Sibling 3

Address of Parents

List child's mother's name and address:				
List child's father's name and address:				

IV-E Information (Complete this section for foster care cases only)

Does DHS have placement and care responsibility?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Child in a voluntary placement over 90 days?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Will child finish school by age 19?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Are parental rights terminated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Date of last RE2 (attach court order)				
Are one or both parents of child incapacitated or deceased?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If both parents in household, is either parent of child employed?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Expected Changes (SW/JCO):		Continuing Eligibility Determination (IMW):	
Social Worker/JCO Signature	Date	IMW Signature	Date

Right of Appeal

If you are dissatisfied with any action or failure to act with regard to your application for Medicaid, you have the right to request an appeal. A hearing must be requested in writing. Send or take your appeal to the Department of Human Services (DHS) office in your county or you may submit it directly to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. You may also file an appeal electronically, at https://dhssecure.dhs.state.ia.us/forms/.

You may present your appeal at the hearing yourself or have someone else present it for you. If you wish, an attorney may represent you at the hearing. However, there are no provisions whereby the Department can pay the attorney fee. Contact your worker for information regarding legal services that may be available in your area.

When the request for a hearing regarding your Medicaid is made within 30 calendar days from the date of notification, a hearing shall be held. When the request for a hearing is made more than 30 calendar days but less than 90 calendar days after the notification, the Director of the Iowa Department of Human Services must approve whether a hearing will be held. Any discussion between you and the county office does not extend this time period.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa Department of Human Services (DHS) to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, religion, age, disability, political belief or veteran status.

If you feel DHS has discriminated against or harassed you, you can send a letter of complaint to:
Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Applicant's copy: Upon request your county Department of Human Services office shall provide a copy of this completed form to you.

CERTIFICATION STATEMENT

I understand that I assume full responsibility for the accuracy of the statements on this form. I understand the Department of Human Services will use this statement to redetermine eligibility for Medicaid.

I am aware that this child's case may be selected by the Department for a complete Quality Control or other review of eligibility for Medicaid. Should this case be selected for verification, I will cooperate fully in the verification.

I know that I must notify the county Medicaid eligibility staff of the changes in the child's income or property or living circumstances. I will report changes to the county office no later than 10 days from the date the change occurs.

I understand that the social security number of the child will be used in the administration of the Medicaid program to check the identity of the child, prevent duplicate participation, and make mass changes. The SSN will be used in computer matching with Iowa Workforce Development, Internal Revenue, and the Social Security Administration and in other program reviews and audits to make sure that the child is eligible for benefits from the Department of Human Services. The SSN will also be furnished to the Internal Revenue Service regarding the benefit eligibility for the child as well as to other states to see if the child is getting benefits from any other state. The information obtained from these computer matches may result in criminal or civil action or administrative claims against persons fraudulently receiving benefits.

I understand that support payments that are assessed and intended for medical expenditures are assigned and must be paid to the Department to the extent of the medical benefits received.

I understand that the Department may intervene to establish paternity and secure medical support on behalf of a child in foster care and secure medical support according, but not limited to, Iowa Code Chapters 232, 234, 252A, 252B, 252C, 252D, 598, and 600B.

I understand that the Department by law does not need my consent to recover Medicaid payments made on the child's behalf. The Department may intervene on the child's behalf to make claim against any person or party that may be responsible for the cost of medical expenses.

I further understand that the Department will provide documents or claim forms describing the services paid by Medicaid upon request or the request of an attorney acting on behalf of the child. These documents may also be provided to a third party when necessary to establish the extent of the Department's claim.

I understand that federal and state law and rules permit access by authorized federal and state officials to Medicaid provider's records. I also fully understand that my acceptance of Medicaid for the child is consent for these authorized persons to have access to the child's medical or other health care records during the time the child is Medicaid eligible. Should my child become enrolled in a managed health care plan, I consent to disclosure of medical information, including any clinical mental health information, by my child's medical providers to the HMO, PHP, other managed care providers, or to the authorized administrative body contracted by the managed care provider to determine appropriateness, quality, or utilization of services my child received while enrolled in managed health care.

I am aware that Section 1128B of the Social Security Act provides federal penalties for fraudulent acts and false reporting. I am aware that Iowa's laws provide that anyone who obtains or attempts to obtain or who aids or abets any person to obtain public assistance to which the person is not entitled is guilty of violating Iowa Code Chapter 294A.

I understand that I will need to provide the Department with proof, either documentation from the INS, or other documents the Department considers to be proof of the immigration status of the child in foster care or subsidized adoption who is not a United States citizen or national. I understand that alien status may be subject to verification with INS, which will require submission of certain information from this application form to INS.

I KNOW WHAT I HAVE REPORTED HERE. I BELIEVE IT IS TRUE, CORRECT AND COMPLETE.
I CERTIFY under penalty of perjury, by signing my name below that I am a U.S. citizen or national or that the information I have given about my immigration status is correct. Adult household members must sign the statement for dependent children.

Signature or Mark of Applicant or Payee (or legal guardian)	Date
Signature or Mark of Other Parent in the Home	Date

FOSTER CARE, ADOPTION, AND GUARDIANSHIP MEDICAID REVIEW
(REVISIÓN DE MEDICAID PARA CRIANZA TEMPORAL, ADOPCIÓN Y TUTELA LEGAL)

PRESENTE ESTE FORMULARIO PARA RECIBIR COBERTURA CONTINUA

INSTRUCCIONES PARA COMPLETAR EL FORMULARIO DE REVISIÓN

Le enviamos este formulario de revisión para cumplir con uno de los requisitos del programa de Medicaid. Es importante que lo complete y lo presente antes de la fecha que figura en el mismo. El formulario debe ser firmado por el padre adoptivo, el tutor legal o por el menor en el programa de vida independiente supervisada, según corresponda. Un asistente de mantenimiento del ingreso de Department of Human Services podría comunicarse con usted. Para tramitar la revisión, dicho asistente podría solicitarle comprobantes adicionales o los datos que necesite, entre ellos, información sobre las personas que colaborarán para pagar la atención médica.

Si no presenta el formulario o no coopera con el proceso de revisión, los pagos por servicios médicos podrían ser interrumpidos. Por lo tanto, le solicitamos su colaboración durante el proceso de revisión. Si desea hacer preguntas, le agradeceremos que se comunique con su asistente de servicios.

INSTRUCCIONES ESPECÍFICAS

Menor en adopción, crianza temporal o tutela legal subvencionada y sus hermanos en el mismo hogar sustituto: Indique el nombre del menor bajo revisión y el nombre de todos sus hermanos que se encuentren en el mismo hogar sustituto. No incluya a los hermanos que vivan en otros sitios. Complete un solo formulario de revisión para el grupo de hermanos.

Condición de alumno: Marque con ✓ si el/la menor es estudiante de tiempo completo o parcial.

Escuela y grado: Indique el nombre de la escuela y el grado al que asisten el/la menor y sus hermanos.

Nombre y domicilio del empleador: Indique el nombre y el domicilio del empleador de cada uno de los menores bajo revisión. Si no están empleados, indique “No corresponde”. Debe presentar el/los comprobante(s) de ingresos laborales del menor correspondiente(s) al corriente mes.

Ingresos: Indique todos los ingresos no laborales que los menores reciben o califican para recibir. Esto significa todos los ingresos no derivados de su trabajo que pueden ser asignados al Departamento, como así también el dinero recibido de parientes y de otras fuentes mencionadas. Indique el monto si lo conoce; de lo contrario, marque cada uno de los ítems que reciben o les corresponde recibir. (Ingresos no laborales son, por ejemplo, los beneficios de Social Security o intereses).

Recursos del menor en adopción, crianza temporal o tutela legal subsidiada y sus hermanos en el mismo hogar sustituto: Indique el tipo de recursos que el/la menor posee y la ubicación de los mismos. En caso de no haber recursos, indique “no.”

Vehículos: Indique si el/la menor es propietario de un vehículo y, en caso afirmativo, ingrese información sobre el mismo.

Seguro médico del menor y los hermanos mencionados: Indique si el/la menor y sus hermanos en el mismo hogar sustituto tienen seguro médico. También ingrese el nombre de titular de la póliza y el nombre de la compañía. De ser posible, indique el número de póliza. Los padres recibirán un formulario más exhaustivo que deberán completar si la póliza ha cambiado.

Domicilio de los padres: Indique el nombre y domicilio de los padres biológicos de los menores en crianza temporal y tutela legal subvencionada, y el nombre y domicilio de los padres adoptivos del menor adoptado. Si los hermanos de los menores en crianza temporal o tutela legal subvencionada tienen diferentes padres, identifique a cada menor en relación con sus padres.

Información para IV-E: Para menores en crianza temporal con forma de vida independiente supervisada, conteste “sí” o “no” a la pregunta sobre la finalización de la educación escolar a los 19 años. **Debe completar toda la sección en el caso de menores en crianza temporal en hogares de familia y guarderías**.

Cambios previstos: Informe todos los cambios que prevea para el futuro del menor, particularmente dentro de los próximos seis meses. Puede incluir los cambios previstos con respecto a cualquiera de los ítems enumerados en este formulario. También indique si la menor está embarazada.

Firma y fecha: El/La menor con forma de vida independiente supervisada, o bien su padre adoptivo o su tutor legal subvencionado, debe firmar este formulario indicando que la información aportada es verdadera, correcta y completa.

Iowa Department of Human Services

Foster Care, Adoption, and Guardianship Medicaid Review
(Revisión de Medicaid Para Crianza Temporal, Adopción y Tutela Legal)

		Mes de Revisión	Fecha de Entrega de de
Asistente Social	Condado Nº	Caso IABC Nº	Asistente de Revisión Médica

Menor en Adopción, Crianza Temporal o Tutela Legal Subvencionada y Hermanos en el mismo Hogar Sustituto
Si necesita más espacio, escriba en una hoja aparte y adjúntela.

	Menor	Hermano 1	Hermano 2	Hermano 3
Nombre del Menor				
Nº de DNI Estatal				
¿Es estudiante?	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial
Nombre de la Escuela y Grado				

Ingresos. Solamente los ingresos del menor.

¿Es empleado?	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial	Si lo es ☐ Tiempo Compl. ☐ Tiempo Parcial
Nombre y domicilio del Empleador (adjunte comprobante(s) de ingresos)				
Beneficios de Social Security	$	$	$	$
SSI (Seguro de Ingresos	$	$	$	$
Manutención de Menores	$	$	$	$
Asignación Militar	$	$	$	$
Parientes/Amigos	$	$	$	$
Intereses	$	$	$	$
Otros ingresos	$	$	$	$

Recursos del Menor en Crianza Temporal, Adopción o Tutela Legal Subvencionada y Hermanos mencionados
Si necesita más espacio, escriba en una hoja aparte y adjúntela.

	Monto	Lugar	Nombre(s) de Titular(es)
Cuenta de cheques ☐ Sí ☐ No			
Cuenta de ahorros ☐ Sí ☐ No			
Acciones y Bonos ☐ Sí ☐ No			
Fondo Fiduciario ☐ Sí ☐ No			
Depósito en custodia ☐ Sí ☐ No			
Otros ☐ Sí ☐ No			

	Marca/Año	Valor de Mercado	Monto adeudado	¿A nombre de quién está?
Automóvil ☐ Sí ☐ No				
Camión/Motocicleta ☐ Sí ☐ No				

Seguro Médico del Menor y los Hermanos mencionados ☐ Sí ☐ No

Personas Cubiertas	Titular de la Póliza	Póliza Nº	Nombre de la Compañía de Seguros

Indique los nombres de los menores:	Menor	Hermano 1	Hermano 2	Hermano 3

Domicilio de los Padres

Indique el nombre y la dirección de la madre del menor				
Indique el nombre y la dirección del padre del menor				

Información para IV-E (Complete esta sección para casos de crianza temporal solamente)

¿Es DHS responsable de la colocación y los cuidados?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
¿Menor en colocación voluntaria por más de 90 días?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
¿Finalizará la escuela a los 19 años?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
¿Cesaron los derechos paternos?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
Fecha del último RE2 (adjunte la orden judicial)	de de	de de	de de	de de
¿Uno o ambos padres están incapacitados o fallecieron?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No
Si ambos padres viven en el hogar, ¿alguno de los dos tiene empleo?	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No	☐ Sí ☐ No

Cambios previstos (Asistente Social/Juzgado de Menores)		Determinación de Elegibilidad Continua (Asistente de IM)	
Firma del Asistente Social/JCO	Fecha de de	Firma del Asistente de IM	Fecha de de

Derecho de Apelación

Si no se siente satisfecho debido a una acción u omisión con respecto a su solicitud de Medicaid, tiene derecho a solicitar una apelación. Debe solicitar una audiencia por escrito. Envíe o lleve su apelación a la oficina de Department of Human Services (DHS) de su condado o envíela directamente a: Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, IA 50319-0114. También puede radicar la apelación por Internet, en: https://dhssecure.dhs.state.ia.us/forms/.

Puede presentar su apelación personalmente durante la audiencia o bien solicitarle a otra persona que lo haga por usted. Si lo desea, un abogado puede representarlo durante la audiencia. Sin embargo, no existe ninguna disposición por la cual el Departamento deba hacerse cargo de los honorarios de su abogado. Comuníquese con su asistente de servicios para obtener más información sobre los servicios jurídicos disponibles en su zona.

Se celebrará una audiencia con respecto a Medicaid si envía la solicitud en un plazo de 30 días corridos a partir de la fecha de notificación. Si la solicitud de audiencia se presenta pasados 30 días corridos pero antes de transcurridos 90 días corridos de la fecha de la notificación, el Director de Iowa Department of Human Services deberá autorizar la audiencia. Este plazo no será prolongado aunque existan controversias entre usted y la oficina del condado.

Política con respecto a Discriminación, Acoso, Acción Afirmativa e Igualdad de Oportunidades Laborales

Es política de Iowa Department of Human Services (DHS) ofrecer trato igualitario en cuanto a empleo y prestación de servicios a los solicitantes, empleados y clientes, sin distinción de raza, color, país de origen, sexo, religión, edad, discapacidad, ideología política o condición de veterano.

Si considera que ha sido víctima de discriminación o acoso por parte del DHS, puede enviar una carta presentando su queja a: Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

Copia para el solicitante: Si lo solicita, Department of Human Services le facilitará una copia de este formulario con todos los datos completos.

DECLARACIÓN DE CERTIFICACIÓN

Entiendo que asumo total responsabilidad por la veracidad de las declaraciones incluidas en este formulario. Entiendo que Department of Human Services utilizará esta declaración para volver a determinar la elegibilidad para Medicaid.

Comprendo que el caso de este menor puede ser seleccionado por el Departamento para llevar a cabo una revisión completa de control de calidad u otro tipo de revisión para determinar su elegibilidad para Medicaid. Si este caso fuera seleccionado, me comprometo a cooperar totalmente para la correspondiente verificación.

Sé que debo notificar al personal encargado de la elegibilidad para Medicaid en el condado sobre cualquier cambio relacionado con los ingresos, bienes o circunstancias de vida del menor. Informaré dichos cambios a la oficina del condado dentro de los 10 días posteriores a la fecha en que éstos ocurran.

Entiendo que el número de Social Security del menor será utilizado en la gestión del programa Medicaid para verificar su identidad, evitar que se duplique la participación y realizar cambios masivos. El número de Social Security será utilizado para comparar datos electrónicamente con Iowa Workforce Department, Internal Revenue y Social Security Administration, así como en otras revisiones y auditorías para confirmar que el/la menor es elegible para recibir las prestaciones de Department of Human Services. El número de Social Security también será facilitado a Internal Revenue Service para verificar su elegibilidad, como así también a otros estados para determinar si el/la menor recibe beneficios de algún otro estado. La información obtenida de estas comparaciones electrónicas puede dar lugar a acciones penales, civiles o administrativas contra aquellas personas que reciben beneficios de manera fraudulenta.

Entiendo que los pagos asistenciales determinados y destinados a gastos médicos serán asignados al Departamento y deberán ser pagados al mismo en la medida de las prestaciones médicas recibidas.

Entiendo que el Departamento puede intervenir, en representación de un menor que se encuentre en crianza temporal, para establecer la paternidad y obtener asistencia médica para el mismo y garantizarle dicha asistencia conforme a los capítulos: 232, 234, 252A, 252B, 252C, 252D, 598 y 600B del Código de Iowa, entre otros.

Entiendo que por ley el Departamento no necesita mi consentimiento para que se le reintegren los pagos de Medicaid realizados en nombre del menor. El Departamento puede intervenir en representación del menor para presentar una demanda contra cualquier persona o parte que sea responsable del pago de gastos médicos.

Entiendo, además, que el Departamento presentará documentos o formularios de reclamo que detallen los servicios pagados por Medicaid a solicitud del menor o bien a solicitud de un abogado que actúe en representación del menor. Dichos documentos también podrán ser facilitados a un tercero cuando sea necesario establecer el alcance del reclamo del Departamento.

Entiendo que las leyes y normas federales y estatales permiten el acceso de funcionarios federales y estatales autorizados a los registros de los proveedores de Medicaid. También entiendo que al aceptar los servicios de Medicaid para este menor doy mi consentimiento para que dichas personas autorizadas puedan acceder tanto a los registros médicos como a otros registros relacionados con el cuidado de la salud durante el período en que el/la menor sea elegible para recibir Medicaid. Si mi hijo/a fuera inscripto/a en un plan médico administrado, doy mi consentimiento para la divulgación de datos médicos, inclusive datos con respecto a su salud mental, a HMO o PHP (Sociedades Médicas), a otros proveedores de cuidado administrado o a la entidad administrativa autorizada contratada por el prestador de cuidado administrado para determinar la aptitud, calidad o aprovechamiento de los servicios que mi hijo/a recibió mientras estuvo inscripto/a en el plan médico administrado.

Tengo conocimiento de que el Artículo 1128B de la Ley de Seguridad Social (Social Security Act) contempla penas de alcance federal para actos dolosos y declaraciones falsas. Tengo conocimiento de que las leyes del estado de Iowa estipulan que toda persona que obtenga o intente obtener o bien ayude o instigue a otra persona a obtener asistencia pública para la cual no esté autorizada es considerada culpable de violar las disposiciones del Cogido de Iowa, Capítulo 294A.

Entiendo que debo presentar pruebas al Departamento, ya sea documentación del INS o bien otros documentos que el Departamento considere como evidencia, de la condición de inmigrante del menor en crianza temporal o adopción subvencionada si el/la mismo/a no posee ciudadanía ni nacionalidad norteamericana. Entiendo que la condición de extranjero puede estar sujeta a verificación por parte del INS, por lo cual será necesario presentar ante el INS información específica incluida en este formulario.

COMPRENDO LA INFORMACIÓN EXPUESTA POR MÍ EN EL PRESENTE FORMULARIO. A MI ENTENDER, LO EXPUESTO ES VERDADERO, PRECISO Y COMPLETO. CERTIFICO bajo pena de cometer perjurio, mediante mi firma, que poseo ciudadanía o nacionalidad norteamericana, o que la información que he proporcionado acerca de mi estado de inmigración es correcta. Los miembros adultos del grupo familiar deben firmar la declaración en representación de los menores a su cargo.

Firma o marca del solicitante o beneficiario (o tutor legal)	Fecha de de
Firma o marca del otro miembro (padre/madre) del grupo familiar	Fecha de de

Foster Care, Adoption, and Guardianship Medicaid Review, Form 470-2914 or 470-2914(S)

Purpose	Form 470-2914 or 470-2914(S) is used for reviewing eligibility factors of children in the FMAP-related coverage groups who are in foster care, subsidized adoption, or subsidized guardianship. The service worker also uses the form for the IV-E review.
Source	The English version of this form is printed with 15 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. The English or Spanish version of the form may also be completed on line using the template on the DHS Intranet eForms web page or in the public state-approved service folder on Outlook. You can also print or photocopy supplies of the form from the sample in the manual.
Completion	Initiate this form a month before the Medicaid review is due. The IM worker completes identifying information. The service worker, the juvenile court officer, the child in supervised apartment living, the parent of a child in subsidized adoption, or the guardian of a child in subsidized guardianship completes the rest of the form. The service worker may photocopy the complete form, if desired.
Distribution	After the service worker, juvenile court officer, child, parent, or guardian completes this form, the original form must be forwarded to the IM worker that sent the form. The service worker may file a photocopy of the completed review form in the service case record. Upon receipt of the form, process the review. Send an *Insurance Questionnaire*, form 470-2826 or 470-2826(S), to the birth parent of the foster child if health insurance has changed. If a child in subsidized adoption out of state appears to be eligible for a regular Medicaid group, notify the child's parents to apply for Medicaid in the state of residence. When eligibility is redetermined under a different coverage group, notify the service worker of the changed eligibility on form 470-2708.

Data

The IM worker shall:

- Enter the month that represents the month in which the medical review is due.
- Complete the Medicaid worker's name and number.
- List the child being reviewed and all of the child's siblings that are in the same placement and in the same eligibility group. If one sibling is IV-E and another is CMAP, two review forms are required. Do not list siblings in other placements.
- Send the form as follows:
  - For a foster child, send the form, together with form 470-2708, *Foster Care or Subsidized Adoption Exchange of Information*, to the service worker or juvenile court officer, unless the child is in supervised apartment living. Remove the instruction page when sending the form to the service worker.
  - When the child is in supervised apartment living, send the form with instructions to the child. Send form 470-2708 to inform the service worker or juvenile court officer that the review is due.
  - For medical reviews of IV-E foster children placed in Iowa from out of state, send the review form to the service worker in the other state. Remove the instruction page.
  - For medical reviews of non-IV-E-foster children placed out of Iowa, send the form to the service worker or juvenile court officer in Iowa that is designated for the foster child. Remove the instruction page.
  - When the child is in subsidized adoption, send the form with the instruction page to the adoptive parent, including children placed out of state or placed in Iowa by another state.
  - When the child is in subsidized guardianship, send the form with the instruction page to the guardian.

- If the review is not completed in a timely manner for the child placed with the juvenile court officer or in supervised apartment living, send another review form to the service worker or chief juvenile court officer and request that the service worker or juvenile court officer complete the review.

  If the form is not completed for a child in subsidized adoption, notify the service worker that the form has not been received. The service worker shall contact the adoptive parent and explain the requirements.

The service worker or juvenile court officer shall do the following when the review form is received:

- Complete the form with the information such as changes in siblings placed together, school attendance, unearned income, escrow account, resources, and list any expected changes.
- Contact the foster child's birth parents or custodial relative to ask about changes that have occurred in the child's resources or unearned income and changes in health insurance.
- Contact the foster child to ask the child to save wage stubs for the whole month before review. Ask the child if the child has any resources, recording the answer on the review form.
- Sign the form.
- At the beginning of the review month, send the review form to the IM worker with form 470-2708 and wage verification.
- If the child does not provide the wage information, obtain it and send it to the IM worker.

When siblings are in the same group, copies of this form should be filed in each of the siblings' individual service records

Free Lunch Notice, Form 470-4473 or 470-4473(S)

Purpose

Forms 470-4473 and 470-4473(S) advise Food Assistance and FIP households that their school-age children are eligible for the free school lunch program. Households should give the form to the school in order to get free lunches. **Note:** The form also provides information about ***hawk-i*** and Medicaid.

The Departments of Human Services (DHS) and Education (DE) electronically match names of children receiving Food Assistance and FIP with school records. The schools will automatically send free lunch approval letters for children identified through this match.

Households receive the form only for children who are not identified by the match.

Source

The form is generated and mailed from Central Office.

Completion

The form is mailed by August 1 each year. Households are responsible to complete the form and provide it to the school. If they do so at least ten days before school starts, the children listed on the form will be able to participate in the school lunch program on the first day of school.

Families are also directed to sign the form if they do not want their name released to the ***hawk-i*** program or if they are currently receiving health insurance benefits through ***hawk-i*** or Medicaid.

Distribution

One copy is mailed to the household. The household is directed to return the form to their local school.

Data

Students will receive free school lunches if:

- The student is identified by the electronic match between DHS and DE as receiving Food Assistance or FIP, or
- The household receives form 470-4473 for the student and provides the form to the school.

Otherwise, the household must complete an application with the school to get free meals.

Health Insurance Information for Kids With Special Needs, Form 470-4633

Purpose	Form 470-4633 is used to determine if children applying under the Medicaid for Kids With Special Needs (MKSN) coverage group meet the health insurance enrollment requirement.
Source	Complete the form on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker initiates an original and one copy of this form when the Department needs to gather information about: ♦ The availability of employer health insurance, ♦ The employer share of the premium cost, and ♦ Enrollment of the child in the health insurance plan. The parents: ♦ Check the correct box to describe their child's health insurance coverage, **and** ♦ Either: • Complete form 470-2826 or 470-2826(S), *Insurance Questionnaire*, **or** • Take the second page of form 470-4633 to their employer to be completed.
Distribution	Mail the original to the parents and file the copy in the case record. The parents must return the completed form to the IM worker along with the information listed above.
Data	The template will populate the name, address, worker identification, and the due date.

Important Information About Your Medicaid Benefits, Form 470-4537

Purpose	Form 470-4537 is used to notify the member that Medicaid will stop paying for most of their prescriptions.
Source	This form is system-generated.
Completion	Central office will mail form 470-4537 to a member: ♦ Two months before a member turns age 65, and ♦ When the Centers for Medicare and Medicaid Services notifies the Department that the member has Medicare benefits.
Distribution	One copy is mailed to the member.
Data	The form explains: ♦ That Medicaid stops paying for most prescriptions when Medicare coverage begins. ♦ What Part D costs Medicare will help pay for because the member receives help from Medicaid. ♦ What will happen if the member does not enroll in a Part D plan. ♦ What the member should do if the member has drug coverage through an employer or union. ♦ Who to call if the member has questions.

Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Important Information About Your Medicaid Benefits

We are sending you this letter because our records show that you are getting or are going to start getting Medi**care**. If you think this is wrong, please call your DHS worker right away.

The Iowa Medi**caid** program will **STOP** paying for most of your prescriptions drugs when your Medi**care** starts. You will need to enroll in a Medi**care** Part D prescription drug plan so that Medi**care** can begin paying for your prescription drugs.

What does it cost? Because you get Medi**caid** you will get help from Medi**care** to pay for the following Part D costs:

- The premium
- The deductible; and
- Drug co-payments

What if I don't enroll? If you do not enroll in a Part D plan, Medi**care** will assign you to a plan. If that plan does not cover all your prescriptions, you may change plans.

What if I have drug coverage through my employer/union? If you have an employer/union plan that has drug coverage and:

- If the coverage is as good as, or better than Medi**care**, you may keep the employer/union plan.
- If you keep the employer/union plan, you must let Medi**care** know so that Medi**care** will not enroll you in a Part D plan.

Questions?? If you need help choosing a Medi**care** Part D plan or if you have questions:

- Call Medi**care** at **1-800-633-4227**; or
- Call the Senior Health Insurance Information Program (**SHIIP**) at **1-800-351-4664**. SHIIP volunteers are trained to help you with your Medi**care** question and can help you choose a Medi**care** Part D plan that meets your prescriptions drug needs.

The information in this letter is based on the following laws: 42 CFR Part 431 Subpart E and the Social Security Act under Section 1935 (d)(1).

Important Information for You and Your Family Members About the Estate Recovery Program, Comm. 123 or Comm. 123(S)

Purpose	The *Important Information for You and Your Family Members About the Estate Recovery Program* is a flyer designed to give answers to questions about the Estate Recovery Program.
Source	The English version of this flyer is printed with 100 flyers per pad. Order supplies from Iowa Prison Industries at Anamosa. Print supplies of the Spanish version from the sample in the manual.
Completion	No completion is required.
Distribution	Issue a copy of this flyer to all Medicaid applicants, including QMB, SLMB and E-SLMB applicants, IowaCare applicants, and to FIP applicants who also apply for Medicaid. Issue the flyer again at each review.

Important Notice to Property Owners and Renters, Comm. 121 or Comm. 121(S)

Purpose	The *Important Notice to Property Owners and Renters* flyer explains the income limits for both the property tax credit and rent reimbursement.
Source	Comm. 121 is printed with 50 copies per pad. Order supplies from Iowa Prison Industries at Anamosa. Print supplies of Comm. 121(S) from the sample in the manual.
Completion	No completion is required.
Distribution	Give or mail Comm. 121 or Comm. 121(S) to elderly and disabled applicants when they apply for benefits. Document this in the case record.

Inability to Find a Responsible Person, Form 470-3356

Purpose	The *Inability to Find a Responsible Person* is completed when an individual or an organization wants to be considered a "responsible person" for a client who is physically incapacitated, incompetent, or deceased and is in need of a "responsible person" to act on their behalf and there is otherwise no person to act in that capacity.
Source	Form 470-3356 is not printed. Photocopy supplies as needed from the sample in the manual, or print the form from the on-line manual.
Completion	The person or organization requesting to be considered as a responsible person completes the form.
Distribution	The party who completed the form submits one copy to the county DHS office and should keep one copy.
Data	The form contains: ♦ The name of the client. ♦ The reason that the client needs representations. ♦ The name of the person proposed to be the responsible person. ♦ The period of time for which responsibility is requested (during application, for ongoing eligibility, or both). ♦ The signature of the proposed responsible person. ♦ The date of the signature. ♦ The name of the business or organization the responsible person is from, if any. ♦ The signature of a person from that organization authorizing this designation. ♦ The position of the authorizing person.

Income Eligibility Verification System (IEVS) Match, Form 470-3779

Purpose	Form 470-3779, *Income Eligibility Verification System (IEVS) Match*, is a cover letter used in conjunction with the Change Reporting System (CRS) to collect information for the Family Investment Program, Food Assistance program, and Medicaid program. This form forwards the *Employer's Statement of Earnings*, form 470-2844, when the worker learns through an IEVS report that the household has earnings. **Note:** This form is used only for IEVS matches that are other than IRS matches. If the information is obtained from an IRS IEVS form, see *Employer's Verification of Earnings*, form 470-3741.
Source	The CRS generates form 470-3779 in response to specific answers provided when completing a Beginning Employment (BEMP) incident screen narrative.
Completion	When a worker learns through an IEVS report (other than an IRS IEVS report) that the household has earnings, the CRS generates this form to send the *Employer's Statement of Earnings* form. The CRS populates certain areas of the form and calculates a due date for the return of the completed form.
Distribution	The system prints two copies. Give one copy to the client and file one copy in the case record.
Data	The CRS populates address and worker information areas of the form, states the earnings information from IEVS, and calculates a due date for the return of the requested information. The client completes the explanation of the income.

Income Worksheet, Form 470-2815

Purpose	Form 470-2815 is used when the EA worker needs more than one income worksheet to determine countable income for a household who has applied for Emergency Assistance.
Source	Supplies of the form may be printed as needed from the on-line manual or photocopied from the printed sample.
Completion	The EA worker completes one copy of the *Income Worksheet* when determining countable income on an application for Emergency Assistance.
Distribution	File the form in the Emergency Assistance case record along with the application. Make a copy of the *Income Worksheet* available to the household upon the household's request.
Data	**I. Earned Income:** List the gross earned income received by each employed member of the household. Total the amounts listed to arrive at the total gross earnings. Subtract amount of verified child care expenses, if applicable. The remaining amount represents the total adjusted (countable) earnings. **II. Unearned Income:** List the countable unearned income received by each member of the household. Total the amounts listed to arrive at the total unearned income. Total the amount of adjusted earnings from Section I and the amount of the total unearned income from Section II. This results in the total amount of combined income to the household. Enter the income limit for the household.

Incomplete Input Document Data, Form 427-0292

Purpose	Form 427-0292, *Incomplete Input Document Data*, informs the worker when data on form 470-0464, *Overpayment Recovery Information Input*, is missing or wrong and gathers the correct information.
Source	Form 427-0292 is issued by the Department of Inspections and Appeals.
Completion	The Overpayment Recovery Unit data entry operator prepares this form when form 470-0464 has been submitted and it is found to be incorrect or incomplete or to require additional information.
Distribution	The Overpayment Recovery Unit sends this form to the worker who submitted the incomplete 470-0464 with the incomplete form attached. (The overpayment is not entered on the Overpayment Recovery System until the form is corrected or completed.) Return both forms to the Overpayment Recovery Unit within 10 days.
Data	The submitting worker shall complete the requested information on this form or on form 470-0464.

Information on Emergency Service, Comm. 84 or Comm. 84(S)

Purpose	The *Information on Emergency Service* leaflet helps applicants to better understand Food Assistance emergency service and the criteria for receiving it. This form allows clients to determine for themselves whether or not they may be eligible for emergency service. This leaflet is mandatory only for counties that choose not to issue an appointment letter that indicates the client's eligibility for an emergency Food Assistance appointment.
Source	Comm. 84 (English) is printed with 25 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. Print copies of the Spanish translation, Comm. 84(S), from on-line manual.
Completion	In counties that choose to distribute information on emergency service with applications, give this leaflet to all Food Assistance applicants at the time they are given: ♦ A *Health and Financial Support Application*, form 470-0462 or 470-0466, or ♦ An *Application for Food Assistance*, form 470-0306 or 470-0307.
Distribution	In a county that chooses not to inform applicants on the appointment letter whether they have been screened as entitled to an emergency appointment, include one copy of Comm. 84 or Comm. 84(S) with the application form.
Data	None.

Inquiry Regarding Bill for Medical Services, Form 470-0391

Purpose	The Iowa Medicaid Enterprise uses form 470-0391 to acknowledge callers on the Medicaid hotline regarding bills for medical services that they feel Medicaid should have paid.
Source	The IME Member Services Unit generates the form.
Completion	IME Member Services staff completes the form for each inquiry concerning a medical bill received through the Medicaid hotline to acknowledge receipt of the call. The form records the information given by the caller and notifies the caller of appeal rights if the Department does not respond to the caller within 30 days of the date the acknowledgment is sent. The form is included in the manual for informational purposes only. No action by the local office is required unless the caller appeals. Appeals are then handled in the usual manner.
Distribution	The IME Member Services staff returns the original to the caller and sends a copy of the form to the Department.
Data	The form identifies: ♦ The caller. ♦ The service provided. ♦ The person receiving the service. ♦ The provider of the service. ♦ The date and amount of the bill. ♦ Notes about previous calls and comments.

Iowa Department of Human Services

Insurance Questionnaire

To ensure that your bills are paid as quickly as possible, please fill out this form and return to your local Department of Human Services (DHS) office.

Your Name: _____ Your State ID number, if any: _____

Do you, your children or others in your home have health insurance coverage? ☐ Yes ☐ No, then stop here.

If yes, who carries this health insurance?

☐ You ☐ A parent who does not live with you

☐ Someone else in your home ☐ Someone else not in your home

Please fill out the information below. The boxes with this mark * must be filled in. Use the next page if you have another policy to tell us about.

Information About First Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement

☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Information About Second Policy

Choose **all** that apply to this policy:

☐ Major Medical ☐ Drug ☐ Medicare Supplement
☐ Dental ☐ Vision

*Policyholder (Last Name, First Name, Middle Initial)		Phone number ( )
Mailing address (House #, Street, Apt, *OR* PO Box, City, State, Zip)		
*Social Security number	*Date of birth	*State ID #
*Insurance company name		Phone number ( )
Insurance claims office mailing address (#, Street, *OR* PO Box, City, State, Zip)		
If the insurance is through an employer, employer's name		
*Policy number	Group number	Date policy is effective

People covered by the policy above:

Fill out the information below and tell us if each person is currently covered or if they are being added or dropped from the insurance.

Currently Covered	Choose One: Add	Drop	Effective Date	Last Name, First Name, Middle Initial	Date of Birth	State ID	Relationship to Policyholder
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Is there anything else about the insurance information you gave that you want to tell about? If yes, please use this space.

For office use only:
County # _____
Worker # _____
Date Rec'd _____

Iowa Department of Human Services

Insurance Questionnaire
(Cuestionario sobre Seguros)

Para garantizar que sus facturas sean pagadas tan pronto como sea posible, le agradecemos que llene este formulario y lo devuelva a su oficina local de Department of Human Services (DHS) office.

Su Nombre: _____ Su Nº de Ident. Estatal, si corresponde: _____

¿Tienen usted, sus hijos u otras personas que vivan en su hogar, cobertura de seguro médico?

☐ Sí ☐ No, entonces no continúe completando el cuestionario

Si respondió afirmativamente, ¿quién es el titular del seguro médico?

☐ Usted ☐ Uno de sus padres, el cual no vive con usted

☐ Otra persona que vive con usted ☐ Otra persona que no vive con usted

Por favor, complete la siguiente información. Las casillas con esta marca * son obligatorias. Utilice la página siguiente si posee otra póliza.

Información acerca de la Primera Póliza

Marque **todos** los que correspondan a esta póliza:

☐ Gastos Médicos Mayores ☐ Medicamentos ☐ Suplemento Medicare

☐ Odontológicos ☐ Oftalmológicos

*Titular de la póliza (Apellido, primer nombre, inicial del segundo nombre)		Teléfono ( )
Dirección postal (Nº de la vivienda, calle, departamento, *O* apartado postal, ciudad, estado, código postal)		
*Número de Social Security	*Fecha de nacimiento	*Nº de Identificación Estatal
*Nombre de la compañía de seguros		Teléfono ( )
Dirección postal de la oficina de reclamos del seguro (Nº, calle, *O* apartado postal, ciudad, estado, código postal)		
Si accede al seguro a través de su empleador, nombre del empleador		
*Número de la póliza	Número de grupo	Fecha de vigencia de la póliza

Personas cubiertas por la póliza anterior:

Llene la siguiente información y díganos si estas personas están cubiertas actualmente o si las agrega o las quita del seguro.

Cubierto actualmente	Elija Uno: Agregar	Quitar	Fecha de vigencia	Apellido, primer nombre, inicial del segundo nombre	Fecha de Nac.	Identificación Estatal	Parentesco con el Titular
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

Información sobre la Segunda Póliza

Marque **todos** los que correspondan a esta póliza:

☐ Gastos Médicos Mayores ☐ Medicamentos ☐ Suplemento Medicare
☐ Odontológicos ☐ Oftalmológicos

*Titular de la póliza (Apellido, primer nombre, inicial del segundo nombre)		Teléfono ( )
Dirección postal (Nº de la vivienda, calle, departamento, *O* apartado postal, ciudad, estado, código postal)		
*Número de Social Security	*Fecha de nacimiento	*Nº de Identificación Estatal
*Nombre de la compañía de seguros		Teléfono ( )
Dirección postal de la oficina de reclamos del seguro (Nº, calle, *O* apartado postal, ciudad, estado, código postal)		
Si accede al seguro a través de su empleador, nombre del empleador		
*Número de la póliza	Número de grupo	Fecha de vigencia de la póliza

Personas cubiertas por la póliza anterior:

Llene la siguiente información y díganos si estas personas están cubiertas actualmente o si las agrega o las quita del seguro.

Cubierto actualmente	Elija Uno: Agregar	Quitar	Fecha de vigencia	Apellido, primer nombre, inicial del segundo nombre	Fecha de Nac.	Identificación Estatal	Parentesco con el Titular
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					
	☐	☐					

¿Desea contarnos algo más con respecto a la información sobre seguros que nos facilitó? En caso afirmativo, por favor utilice este espacio.

Para Uso Exclusivo de la Oficina:
Condado Nº _____
Asistente Nº _____
Fecha de Registro _____

Insurance Questionnaire, Form 470-2826 or 470-2826(S)

Purpose	The *Insurance Questionnaire* is used to identify clients who have health insurance or other medical resources available to them. It is also used as an input document for transmitting information to the Third-Party Liability subsystem and the Automated Benefit Calculation (ABC) system.
Source	The English version of form 470-2826 is printed with 100 forms on a pad. Order supplies from Iowa Prison Industries at Anamosa. Both the English and Spanish versions of this form are available on line as templates on the DHS Intranet eForms web page.
Completion	Include this form in the application packet. Also give or mail a form to the client to complete when the client reports a change in medical resources (for example, on the review form). The client or the client's representative completes one copy of the form at the time of application and when a change in medical resources occurs.
Distribution	When an *Insurance Questionnaire* is received in the local office, dispose of it as follows: ♦ If the form indicates no insurance coverage, file it in the case record. ♦ If the form indicates Medicare coverage only, enter the information into the ABC system TD03 screen according to instructions in 14-B-Appendix. Then file the form in the case record. ♦ If the form indicates Medicare coverage plus other insurance, enter the Medicare information into the ABC system as indicated above and then send the form via local mail to Iowa Medicaid Enterprise (IME) Revenue Collection Unit. ♦ If the form indicates coverage from any source not addressed above, send the form via local mail to the IME Revenue Collection Unit.

When you send the form to IME, you may keep a copy of the form in the case record. However, this is not mandatory because IME will scan all forms to the workflow processing system.

- ♦ When a form is returned indicating coverage has stopped:
  - Ensure that the name of the insurance company and the client's state identification number are on the form,
  - Write TERMINATED across the top of the form, and
  - Send it to Iowa Department of Human Services, Bureau of Long Term Care, 100 Army Post Rd, Des Moines, IA 50315.

Iowa
Fields of Opportunities

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR
SERVICE AREA MANAGER

Dear

It has come to my attention that you have health insurance through _____ _____.

Please provide the following information by _____. If we don't get the information by this date, then your IowaCare benefits may be canceled.

Does your health insurance cover pre-existing conditions?	☐ Yes	☐ No
Are services you need from IowaCare covered by your health insurance?	☐ Yes	☐ No
Does your health insurance have a limit on benefits?	☐ Yes	☐ No
If yes, have you reached that limit?	☐ Yes	☐ No

Additional comments: _____

_____

_____

If you have any questions or need more time to get the information, please call me on or before _____.

Sincerely,

IowaCare Insurance Information Request, Form 470-4542

Purpose	The *IowaCare Insurance Information Request* is sent to request needed health insurance information from the member. IowaCare members are to report within 10 days that they have health insurance. This is new information.
Source	Complete form 470-4542 on line using the template on the DHS Intranet eForms web page.
Completion	The IM worker completes form 470-4242 when the worker receives a request to verify that IowaCare eligibility exists based on the health insurance meeting one of the exceptions for IowaCare.
Distribution	The IM worker sends the form to the IowaCare member.
Data	The form includes the: ♦ Member's name ♦ Health insurance company's name ♦ Date information is due ♦ IM worker's name

IowaCare Medical Card, Form 470-4164

Purpose	The *IowaCare Medical Card* is a card that contains basic identifying eligibility information concerning an IowaCare member with restrictions to specific providers and services. The mailer containing the card has contact information for members who have questions and states that there is limited coverage.
Source	The card is issued by Central Office Data Management Division.
Completion	The card is generated at the beginning of each certification period for new approvals and reinstatements. If the member loses the card, the card is damaged, or the card is mismailed due to an unreported change of address, the member should contact the IME Member Services Unit at 1-800-338-8366 (or at 725-1003 for those living in Polk County).
Distribution	One copy of the card is automatically issued.
Data	The member's name, plan ID, and plan number are printed on the card. The back of the card provides information on where to send claims and contact phone numbers for any questions.

Iowa Department of Human Services

MAC INCOME WORKSHEET

CASE NAME:	CASE NUMBER:	DATE: March 31. 2009
APPLICATION MONTH:	BENEFIT MONTH:	

I. RESPONSIBLE PERSON INCOME (stepparent, self-supporting parents, etc.)

EARNED INCOME EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Total gross earnings $

20% earned income deduction -

Child care expenses -

Unearned income +

Child support, alimony or other payments to people outside the home -

RP/dependent diversion -

A. Responsible Person Income = $

II. EARNED INCOME

EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Total gross earnings = $

20% earned income deduction -

Adult/child care expenses -

Court-ordered child support paid to people outside the home -

B. Countable Earned Income = $

EMPLOYEE: EMPLOYER:

Date Paid	Gross	Tips	Total
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Total gross earnings = $

20% earned income deduction -

Adult/child care expenses -

Court-ordered child support paid to people outside the home -

C. Countable Earned Income = $

III. UNEARNED INCOME

Unearned income of children $

Unearned income of parent +

Child support: $ minus exemption +

Court-ordered child support paid to persons outside the home (any remaining amount) -

D. Total Unearned Income = $

E. Total Countable Income Subtotal (Total of boxes A through D) = $

E. Total countable income from previous page: $ Household size:

Check the box for the applicable period:

☐ **Poverty Levels *After* April 1, 2009**

Maximum income limit at 133% of poverty (If income does not exceed this amount, children age 1 through age 18 are eligible. $

Maximum income limit at 200% of poverty (If income does not exceed this amount, pregnant women and infants under age one are eligible.) $

NOTE: Consider an unborn child in determining the size of the household. Do not consider the stepparent in determining the size of the household if the stepparent is not included in the eligible group.

☐ **Poverty Levels *Before* April 1, 2009**

Maximum income limit at 133% of poverty (If income does not exceed this amount, children age 1 through age 18 are eligible.) $

Maximum income limit at 200% of poverty (If income does not exceed this amount, pregnant women and infants under age one are eligible.) $

NOTE: Consider an unborn child in determining the size of the household. Do not consider the stepparent in determining the size of the household if the stepparent is not included in the eligible group.

Notes:

☐ Original
☐ Revised

Iowa Department of Human Services

Notice of Attribution of Resources

Today's Date _____

Effective Date _____

Worker	County No.	Phone ( )
Name of Spouse in Facility or Waiver	Social Security Number	
Name of Spouse at Home	Social Security Number	

The amount of your resources as of the first of the month in which the spouse named above entered a medical facility are listed below. If you want to apply for Medicaid, you must also complete either the *Health and Financial Support Application* or the *Health Services Application*.

Countable Resources	Spouse in Facility	Spouse at Home	Total
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
The resources not counted are:		**Total**	

The amount of resources attributed to the spouse at home is:

☐ The minimum community spouse resource allowance of $.

☐ The maximum community spouse resource allowance of $. The maximum resource allowance will change each January. Contact the Department of Human Services to find out the revised amount.

☐ The amount established by court order $.

☐ The amount adequate to provide the minimum monthly maintenance needs allowance. The community spouse resource allowance per the appeal decision of $.

☐ One-half of the total countable spousal resources $.

All remaining resources are attributed to the spouse in the facility. The resource limit for the institutionalized spouse is $2,000. As of the date of entry, the institutionalized spouse is attributed $.

If you disagree with this attribution or believe that the income generated by the amount attributed to the spouse at home is not enough to meet the minimum monthly maintenance needs allowance of $2,739 for the spouse at home, you have the right to appeal. See the back of this form.

Retain this form for your Medicaid application when you need medical assistance.

The institutionalized spouse must transfer the resources attributed to the community spouse to the community spouse to remain eligible within 90 days of the date Medicaid eligibility is established. See your worker for further information.

You Have the Right to Appeal

What is an appeal?

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How do I appeal?

Filing an appeal is easy. You must appeal in writing by doing **one** of the following:

- Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/, **or**
- Write a letter telling us why you think a decision is wrong, **or**
- Fill out an Appeal and Request for Hearing form. You can get this form at your county DHS office.

Send or take your appeal to the Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. If you need help filing an appeal, ask your county DHS office.

How long do I have to appeal?

You must file an appeal:

- Within 30 calendar days of the date of a decision or
- Before the date a decision goes into effect

If you file an appeal more than 30 but less than 90 calendar days from the date of a decision, you must tell us why your appeal is late. If you have a good reason for filing your appeal late, we will decide if you can get a hearing.

If you file an appeal 90 days after the date of a decision, we cannot give you a hearing.

Can I continue to get benefits when my appeal is pending?

You may keep your benefits until an appeal is final or through the end of your certification period if you file an appeal:

- Within 10 calendar days of the date of a decision or
- Before the date a decision goes into effect

Any benefits you get while your appeal is being decided may have to be paid back if the Department's action is correct.

How will I know if I get a hearing?

You will get a hearing notice that tells you the date and time a telephone hearing is scheduled. You will get a letter telling you if you do not get a hearing. This letter will tell you why you did not get a hearing. It will also explain what you can do if you disagree with the decision to not give you a hearing.

Can I have someone else help me in the hearing?

You or someone else, such as a friend or relative can tell why you disagree with the Department's decision. You may also have a lawyer help you, but the Department will not pay for one. Your county DHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

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Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; phone (800) 972-2017; fax (515) 281-4243.

Notice of Attribution of Resources, Form 470-2588

Purpose	Form 470-2588 is used to notify both spouses of what resources are protected for the community spouse.
Source	Complete form 470-2588 on line using the template on the DHS Intranet eForms web page.
Completion	The income maintenance worker prepares the form when the local office makes a decision on the attribution of resources.
Distribution	Mail a copy to each spouse and file a copy in the case record.
Data	Enter the date and the income maintenance worker's name, county, and phone number. Enter the names and social security numbers of the spouse in the facility and the spouse at home. List all countable resources of both spouses and indicate the excluded resources. If there are jointly owned countable resources, list these under the column of each spouse by dividing the value in half. The form will calculate a total of the combined countable resources as they are entered and will automatically determine the amount of protected resources for the community spouse as directed in 8-D, Calculating the Amount to Attribute to the Community Spouse. The correct check box will automatically be marked based upon the calculation of the protected amount for the community spouse. The remainder of the resources will be assigned to the spouse in the medical institution. The form will automatically enter the minimum monthly maintenance needs allowance (MMMNA) that is in effect at the time of determination of attribution in the paragraph beginning "If you disagree." The worker has the ability to change this amount when needed.

Iowa Department of Human Services

Notice of Cancellation/Redetermination

Co. No:

Case No:

Worker Name:

Notice Date:

If you have questions, phone your worker at:

We will accept collect calls from live outside the local calling area.

Email:

Your medical assistance will be canceled effective , under your current coverage group because

Manual references:

Legal references:

Your medical assistance will continue until the above date while Medicaid eligibility under other coverage groups is being determined.

If you wish to appeal the cancellation of your case, see the reverse side for appeal rights. Your county Department of Human Services will assist you in filing an appeal if you ask them, or you may contact Iowa Legal Aid at 1-800-532-1275, or if you live in Polk County at 243-1193.

☐ To determine your eligibility under another coverage group, the following verification is needed:

The requested information must be received in the county office by .

When the requested information is received in the county office by this date, your worker will then determine if you are eligible for Medicaid under another coverage group and notify you of the results. If the requested information is <u>not</u> received in the county office by this date, you will have to reapply for Medicaid benefits.

Return this form to:

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Iowa Department of Human Services

Notice of Decision

Worker Name

Case Number

Worker Phone

Please review the entire notice. If you have questions, call your worker. We take collect calls.

You may look at the Employees Manual (EM) at the department's county office. You have the right to ask for an appeal. If you want an appeal, read and follow the steps on the back of this page. If you need help in filing your appeal, you can ask for help from your county office or you may call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193 for Legal Aid.

See the other side of this notice for the action taken on your case.

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(Food Assistance only) USDA - Director Office for Civil Rights, Rm 326-W Whitten Bldg, 1400 Independence Ave SW, Washington DC 20250-9410, or call 1-800-795-3272 voice or (202) 720-5964 (TDD).

Iowa Department of Human Services

Notice of Decision (Aviso de decisión)

Nombre del trabajador

Número del caso

Número del trabajador

Por favor lea detenidamente todo el contenido de la notificacion. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

Usted puede mirar el Manual del Empleado (EM) en la oficina del Condado. Tiene derecho a solicitar una apelación. Si desea una apelación, lea y siga los pasos que se indican al reverso de esta página. Si necesita ayuda para presentar su apelación, puede pedirla a su oficina de condado, o puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Polk County, llame al 243-1193.

Ver el reverso de este aviso para anotar la acción tomada en su caso.

Usted tiene derecho a apelar

¿Qué es una apelación?

Una **apelación** es solicitar una audiencia porque no le guste una decisión que haya tomado el Department of Human Services (Departamento de Servicios Humanos) (DHS). Tiene derecho a apelar si no está de acuerdo con una decisión. No tiene que pagar para presentar una apelación. [441 Código Administrativo de Iowa, Capítulo 7].

¿Cómo debo apelar?

Presentar una apelación es sencillo. Debe apelar por escrito para todos los programas, excepto para Food Assistance (Asistencia Alimenticia). Puede apelar personalmente o por teléfono en el caso de Food Assistance. Para apelar por escrito, haga **una** de las siguientes cosas:

- Complete una apelación electrónicamente en https://dhssecure.dhs.state.ia.us/forms/, o
- Escriba una carta en la que nos diga por qué cree que la decisión está errada, **o**
- Llene un formulario de Apelación y Solicitud de Audiencia. Puede obtener este formulario en la oficina del DHS de su condado.

Envíe o lleve su apelación al Department of Human Services, Appeals Section, 5th Floor, 1305 E Walnut Street, Des Moines, Iowa 50319-0114. Si necesita ayuda para llenar una apelación, solicítela en la oficina del DHS de su condado.

¿Cuánto tiempo tengo para apelar?

Para Food Assistance, tiene 90 días calendario para presentar una apelación, a partir de la fecha de la decisión. Para todos los otros programas, debe presentar una apelación:

- Dentro de los 30 días calendario después de la fecha de una decisión o
- Antes de la fecha en que una decisión se haga efectiva.

Si presenta una apelación entre los 30 y los 90 días después de la fecha de una decisión, deberá decirnos por qué su apelación se hace tan tarde. Si tiene una buena razón para presentar su apelación con retraso, nosotros decidiremos si tiene derecho una audiencia.

Si presenta una apelación 90 días después de la fecha de una decisión, no le podremos conceder una audiencia.

¿Puedo continuar recibiendo los beneficios mientras mi apelación esté pendiente?

Usted puede conservar sus beneficios hasta que una apelación llegue a su fin o hasta el final de su período de certificación si presenta una apelación:

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Cualquier beneficio que obtenga mientras se decida una apelación es posible que lo deba regresar si la acción del Departamento es correcta.

¿Cómo sabré si se me concedió la audiencia?

Recibirá un aviso de audiencia que le informará la fecha y hora en que se ha programado una audiencia telefónica. Recibirá una carta en la que se le informa si no se le concedió la audiencia. Esta carta le dirá por qué no obtuvo la audiencia. También le explicará lo que puede hacer si no está de acuerdo con la decisión de no concederle la audiencia.

¿Puedo tener ayuda para la audiencia?

Usted o alguien más, como un amigo o un pariente, puede decir por qué no está de acuerdo con la decisión del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará dicho abogado. La oficina del DHS de su condado puede darle información sobre servicios legales. El costo de los servicios legales se basará en sus ingresos. También puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Polk County, llame al 243-1193.

Política Relativa a la Discriminación, el Acoso, la Acción Afirmativa, y la Oportunidad Igualitaria de Empleo

Es política del Iowa Department of Human Services ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, religión, edad, incapacidad, creencia política o estatus de veterano.

Si usted considera que el IDHS le ha discriminado o acosado, puede enviar una carta quejándose a:

Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

(Food Assistance only) USDA – Director Office for Civil Rights, Rm 326-W Whitten Bldg, 1400 Independence Ave SW, Washington DC 20250-9410, o llamada 1-800-795-3272 voz o (202) 720-5964 (TDD).

WKR. NO.

CO. NO.

NOTICE DATE

CASE NO.

Iowa Department of Human Services

Notice of Decision

Worker Name

Worker Phone

Worker Email

Please review the entire notice. If you have questions, call your worker. We take collect calls.

You have the right to ask for an appeal. If you want an appeal, read and follow the steps on the back of this page. If you need help in filing your appeal, you can ask for help from your county office or you may call Iowa Legal Aid at 1-800-532-1275. If you live in Polk County, call 243-1193 for Legal Aid.

* EM

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FOOD ASSISTANCE BENEFIT CALCULATION

GROSS INCOME STANDARD TEST:

Number of Persons Considered			
Gross Income Limit			
Gross Unearned Income			
Gross Earned Income	+		
Total Countable Income			

BENEFIT CALCULATION:

Gross Unearned Income				
Gross Earned Income			-	
Earned Income Deduction				
Total Countable Income				
Standard Deduction		-		
Other Deductions Considered:				
Medical Deduction	-			
Child Support Deduction	-			
Dependent Care Deduction	-			
Shelter Deduction	-			
Utility Deduction	-			
Total Deduction Allowed *		-		
Final Countable Income				
Monthly Food Assistance Benefit				
Recoupment				-
Food Assistance Benefit				

* Only verified medical, dependent care, shelter, and utility costs were used to figure this deduction. To be deducted, any missing verification of these expenses must be received before the first of next month or by the tenth day after your report was due, whichever is later.

TRABAJADOR NO.

CO. NO.

FECHA DEL AVISO

CASO NO.

Iowa Department of Human Services

Notice of Decision (Aviso de Decisión)

Nombre de trabajador

Teléfono del trabajador

E-mail del trabajador

Por favor lea detenidamente todo el contenido de la notificacion. Si tiene dudas, llame a su asistente. Aceptamos llamadas por cobrar.

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Usted Tiene Derecho a Apelar

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Cualquier beneficio que obtenga mientras se decida una apelación es posible que lo deba regresar si la acción del Departamento es correcta.

¿Cómo sabré si se me concedió la audiencia? Recibirá un aviso de audiencia que le informará la fecha y hora en que se ha programado una audiencia telefónica. Recibirá una carta en la que se le informa si no se le concedió la audiencia. Esta carta le dirá por qué no obtuvo la audiencia. También le explicará lo que puede hacer si no está de acuerdo con la decisión de no concederle la audiencia.

¿Puedo tener ayuda para la audiencia? Usted o alguien más, como un amigo o un pariente, puede decir por qué no está de acuerdo con la decisión del Departamento. También podrá tener ayuda de un abogado, pero el Departamento no pagará dicho abogado. La oficina del DHS de su condado puede darle información sobre servicios legales. El costo de los servicios legales se basará en sus ingresos. También puede llamar a Iowa Legal Aid al 1-800-532-1275. Si vive en Polk County, llame al 243-1193.

Política Relativa a la Discriminación, el Acoso, la Acción Afirmativa, y la Oportunidad Igualitaria de Empleo

Es política del Iowa Department of Human Services ofrecer trato igualitario en cuanto a empleo y ofrecimiento de servicios a los solicitantes, empleados y clientes, sin importar su raza, color, nacionalidad, sexo, religión, edad, incapacidad, creencia política o estatus de veterano.

Si usted considera que el IDHS le ha discriminado o acosado, puede enviar una carta quejándose a:
Iowa Department of Human Services, Administrator, Diversity Program Unit, 1305 E. Walnut, Des Moines IA 50319-0114; teléfono (800) 972-2017; fax (515) 281-4243.

(*Food Assistance only*) USDA – Director Office for Civil Rights, Rm 326-W Whitten Bldg, 1400 Independence Ave SW, Washington DC 20250-9410, o llamada 1-800-795-3272 voz o (202) 720-6382 (TTY).

CÁLCULO DEL BENEFICIO DE FOOD ASSISTANCE (ASISTENCIA ALIMENTICIA)

PRUEBA STANDARD DE INGRESO EN BRUTO:

Número de Personas Consideradas			
Límite de Ingresos Bruto			
Ingreso Bruto Diferente de Ingresos por Trabajo			
Ingreso Bruto Trabajo	+		
Total Ingresos Contables			

CÁLCULO DEL BENEFICIO:

Ingreso Diferente de Ingresos por Trabajo					
Ingreso Bruto Trabajo			-		
Deducción por Ingreso por Trabajo					
Total Ingresos Contables					
Deducción Estandar		-			
Otras Deducciones Consideradas:					
Deducción Médica	-				
Deducción por Apoyo Infantil	-				
Deducción por Cuidado de Dependiente	-				
Deducción por Albergue	-				
Deducción por Servicios Públicos	-				
Deducción Total Permitida *		-			
Ingresos Contables Finales					
Beneficio Mensual de Food Assistance					
Recuperación				-	
Beneficio de Food Assistance					

* Para calcular esta deducción únicamente se utilizaron costos médicos, de cuidado de dependiente, de albergue y de servicios públicos. Para recibir la deducción, las verificaciones faltantes de estos gastos deben ser recibidos antes del primero del, mes siguiente o antes del décimo día después de vencido su reporte, cualquiera de los dos que suceda más tarde.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Memorándum Interno
(Interoffice Memorandum)

Para/Oficina:
Atención:
De: Ronda Johnson, DHS Liaison for Appeals (Enlace de Apelaciones de DHS)
Tema: Apelación Nº
Caso Nº

Instrucciones para expedir una *Notificación de Descalificación* *(Notice of Disqualification)*

Se adjunta *Notificación de Descalificación* (470-0288). La misma debe ser enviada con posterioridad a la Resolución Final de esta apelación. Nuestros registros indican que esta es la 1ra infracción del demandado. Si no está de acuerdo con la cantidad de violaciones intencionales al programa (IPV, por sus siglas en inglés), por favor llame a la Sección de Apelaciones (Appeals Section) al teléfono (515) 281-8774.

Debe enviar esta *Notificación de Descalificación* al demandado.

En el caso de demandados que actualmente reciban Food Assistance (Asistencia para Alimentos), deberá aplicar la descalificación el primer mes que se pueda tomar dicha medida, por medio de registros en el sistema IABC. Después de registrarla, envíe la *Notificación de Descalificación* por correo.

En el caso de demandados que actualmente no estén recibiendo Food Assistance, envíe la notificación en un plazo de 10 días a partir de la fecha de la Resolución Final.

A continuación se explica cómo llenar la *Notificación de Descalificación*:

1. Haga clic en “Tools” (Herramientas), después elija la opción “Protect Document” (Proteger documento). A continuación, haga clic en “Forms” (Formularios) y luego haga clic en “OK” (Aceptar). Esto le permitirá escribir la información necesaria. En caso contrario, puede imprimir la notificación y llenarla a mano.
2. Haga clic en las casillas de color gris ubicadas en la parte superior de la carta y complete los campos “Fecha de notificación”, “Condado”, “Nombre del Asistente”, “Número del Asistente” y “Teléfono”.
3. Para registrar si ésta es la 1ra, 2da o 3ra infracción del demandado, haga clic en la caja de lista desplegable y luego elija el número correcto.
4. Escriba la fecha de inicio y la fecha de finalización del período de descalificación, si corresponde. En el caso de demandados que actualmente no estén recibiendo Food Assistance, la fecha de inicio será el mes siguiente al mes en que se expidió la Resolución Final.
5. Haga clic en la casilla de verificación y complete la sección correspondiente a la elegibilidad para Food Assistance del resto de la familia.

6. Escriba su nombre o firme al pie de la carta.
7. Haga dos copias. Envíe el original al demandado, guarde una copia en su expediente del caso y envíe la otra copia por fax a Appeals Section al teléfono (515) 281-4597 para el expediente de la apelación.

STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

Notice of Disqualification
(Notificación de Descalificación)

Fecha de notificación:
Condado:
Número del Asistente:
Nombre del Asistente:
Teléfono:

Estimado/a

Usted cometió la 1ra violación intencional al programa (IPV, en inglés). Por dicha razón, no recibirá Food Assistance (Asistencia Alimentaria) durante el siguiente período de tiempo:

☐ Un período de 12 meses que comenzará el _____ y finalizará el _____.

☐ No recibirá Food Assistance nuevamente porque ha sido sancionado de por vida.

El gobierno estatal y el gobierno federal también pueden iniciar un juicio en su contra u obligarlo a reintegrar el monto de Food Assistance que su familia recibió por error.

☐ El resto de los miembros de su familia pueden recibir Food Assistance. Este beneficio comenzará el _____ y finalizará el _____. El monto de Food Assistance que su familia puede recibir podría cambiar de acuerdo a otros factores de elegibilidad. Si el monto de Food Assistance cambia, la familia recibirá una nueva Notificación de Resolución. Una vez que el período de certificación finalice, su familia deberá llenar una nueva solicitud en la oficina local de DHS.

☐ El resto de los miembros de su familia podrían recibir Food Assistance, pero deberán llenar una nueva solicitud en la oficina local de DHS.

☐ El resto de los miembros de su familia ya no pueden recibir Food Assistance.

Si cree que se ha tomado una decisión equivocada con respecto a Food Assistance para su familia, puede apelar. Si desea hacer preguntas, llámeme al teléfono indicado anteriormente.

Muchas gracias por su colaboración.

Income Maintenance Worker
(Asistente de Mantenimiento del Ingreso)

Notice of Disqualification, Form 470-0288 or 470-0288(S)

Purpose

The *Notice of Disqualification* is used to:

- Notify a person who has been found to have committed an intentional program violation of the period of disqualification.
- Notify the remaining household members, if any, of the benefits they will receive during the period of disqualification, or that they must reapply for Food Assistance because the certification period has expired.

Source

The form is an electronic template generated by the DHS Appeals Section and e-mailed to the IM worker.

Completion

The Appeals Section generates this form when an administrative law judge finds a client guilty of intentional program violation in the Food Assistance program.

The local office may also request a form from the Appeals Section when the Department of Inspections and Appeals, Investigations Division, has notified the worker that a court has found that the household member committed an intentional program violation.

The Appeals Section completes the address and identifying information. The IM worker completes the notice fields.

Distribution

The Appeals Section sends the form to the IM worker by electronic mail for completion and printing. The IM worker:

- Sends the original to the client.
- Places a copy in the client's file.
- Sends a copy to the Appeals Section once the disqualification is implemented.

Data

The Appeals Section completes the names, addresses, appeal numbers, and salutations. The IM worker completes the length of sanction and the effect on household benefits, following the instructions given, and signs the form.

Reporting Food Assistance Changes, Form 470-2960 or 470-2960(S)

Purpose	*Reporting Food Assistance Changes* is the form used to inform Food Assistance households how to report changes. The form shows the maximum gross monthly income for the household's size.
Source	Complete the English or Spanish version of this form on line using the templates on the DHS Intranet eForms web page.
Completion	Issue this form: ♦ At application. ♦ At recertification.
Distribution	Send or give the original form to the household and keep a copy of the form in the case file.
Data	Complete the client name, address, date, and case number on the form. Fill in the gross monthly income applicable for household size.

Iowa Department of Human Services

Reporting Food Assistance Changes

Date:

Case #:

Important information:

This form is for the Food Assistance Program only. If you get Medical or FIP, you must report changes for those programs within 10 days.

What do I have to report?

You must tell us if your household's total gross income goes over $_____ in any month. Gross income is the amount before taxes and other deductions are taken out. At the end of each month:

Step 1. Add up all of the gross income your household got in the month. $_____

Step 2. Subtract child support your household paid in the month. - _____

Step 3. Write down how much is left. $_____

Step 4. **If the amount in Step 3 is more than $_____, you must tell us by the 10th of the next month.**

You may report other kinds of things if you want to.

What if I don't report?

You might have to pay back benefits if you don't report when you should. You risk being cut off from Food Assistance for a year or more if you don't report on purpose.

How do I report?

Report changes to **1-877-DHS-5678** or **1-877-347-5678**. You may fax changes to **1-877-238-0015** or e-mail **IMCustomerSC@dhs.state.ia.us.**

Iowa Department of Human Services

Reporting Food Assistance Changes
(Informar Cambios para Food Assistance)

Fecha:

Caso Nº:

Información importante:

Este formulario es para el Programa Food Assistance únicamente. Si recibe Asistencia Médica o FIP, debe informar los cambios para dichos programas en un plazo de 10 días.

¿Qué debo informar?

Debe decirnos si el ingreso bruto total del grupo familiar supera $ _____ en algún mes.
El ingreso bruto es el importe antes de descontar impuestos y otras retenciones. Al final de cada mes:

Paso 1. Sume los importes de ingresos brutos de todo su familia en el mes. $_____

Paso 2. Reste la manutención de hijos que su familia pagó en el mes. - _____

Paso 3. Escriba cuánto queda. $_____

Paso 4. **Si el monto del Paso 3 es más de $_____, debe informarnos antes del día 10 del mes siguiente.**

Puede informar otro tipo de cosas si lo desea.

¿Qué pasa si no informo?

Si no informa a su debido tiempo, podría tener que reembolsar los beneficios. Se arriesga a que le corten Food Assistance por un año o más si deliberadamente no informa los cambios.

¿Cómo informo?

Informe los cambios a los teléfonos **1-877-DHS-5678** o **1-877-347-5678**. Puede informar los cambios por fax al **1-877-238-0015** o por correo electrónico a **IMCustomerSC@dhs.state.ia.us**.

Page 410 is reserved for future use.

Page 411 is reserved for future use.

Iowa Department of Human Services

Verifying Citizenship and Identity

Important Notice!

Federal Medicaid Law Requires Proof of U.S. Citizenship and Identification

U.S. citizens who apply for or get Medicaid will need to show proof of citizenship and identity. **Note:** In most cases, if you were born in the United States you are a U.S. citizen.

Questions or Need Help?

- Call our toll-free number 1-877-937-3663.
- Contact your worker.
- Visit the website at http://www.dhs.state.ia.us/.
- Visit the website at www.cdc.gov/nchs/w2w.htm if you need to get a birth certificate from another state.

Examples of How to Prove U.S. Citizenship and Identity

Everyone in your home who gets Medicaid will need to turn in proof of citizenship and identity, except people who are in foster care or a IV-E subsidized adoption, and people who get Medicare, Supplemental Security Income (SSI), or social security disability. **Proof must be an original document. Do not mail original documents. Bring them to the office.**

- **Column A** proves both citizenship and identity.

If you don't have a document from column A, then you will need to provide documents from column B.

- **Column B** requires a document from both Part 1 and Part 2 to meet the new requirement.

Column A	Column B	
Proves both Citizenship & Identity	**Part 1**	**Part 2**
	Proves only Citizenship	**Proves only Identity**
• U.S. passport, even if expired • Certification of Naturalization (Form N-550 or N-570) • Certification of Citizenship (Form N-560 or N-561)	• Official birth certificate issued by the county or state • Letter from hospital of birth • Other acceptable proof of citizenship	• Drivers license or ID card from the Department of Transportation • School photo ID • School, day care or medical records (for children) • Military ID or dependent card • Other acceptable proof of ID

Important: You must do this for every U.S. citizen in your family who gets Medicaid.

Eligibility will not be affected by race, creed, color, national origin, age, disability, political beliefs, religion, or sex, except where it is required by law.

Comm. 258 (Rev. 3/09)

Iowa Department of Human Services

Verifying Citizenship and Identity
(Verificación de ciudadanía e identidad)

¡Aviso Importante!

La ley federal de Medicaid exige prueba de ciudadanía los Estados Unidos (EE. UU.) y identificación

Los ciudadanos estadounidenses que solicitan u obtengan Medicaid tendrán que mostrar prueba de ciudadanía e identidad. **Nota:** En la mayoría de los casos, si usted nació en los Estados Unidos, usted es un ciudadano estadounidense.

¿Tiene preguntas o necesita ayuda?

- Llame a nuestro número gratuito 1-877-937-3663.
- Contacte a su trabajador.
- Visite el website www.dhs.state.ia.us/citizen.
- Visite el website www.cdc.gov/nchs/w2w.htm si necesita obtener un certificado de nacimiento de otro estado.

Ejemplos de cómo probar la ciudadanía de los EE.UU. y la identidad

Toda persona de su hogar que reciba Medicaid deberá presentar prueba de ciudadanía e identidad, salvo aquellos que estén en hogar sustituto o adopción subsidiada IV-E, y quienes reciban Medicare, Supplemental Security Income (SSI) o incapacidad de seguridad social. **La prueba debe ser un documento original. No envíe por correo los documentos originales. Tráigalos a la oficina.**

- **La Columna A** prueba tanto ciudadanía como identidad.

Si usted no tiene un documento de la columna A, deberá suministrar documentos de la columna B.

- **La Columna B** exige un documento tanto de la Parte 1 como de la Parte 2 para cumplir con el nuevo requisito.

Columna A	**Columna B**	
Prueba tanto Ciudadanía como Identidad	**Parte 1**	**Parte 2**
	Prueba sólo ciudadanía	**Prueba sólo identidad**
• Pasaporte estadounidense, aún vencido • Certificado de naturalización (formulario N-550 o N-570) • Certificado de ciudadanía (formulario N-560 o N-561)	• Certificado de nacimiento oficial emitido por el condado o el estado • Carta de una maternidad • Otra prueba de ciudadanía aceptable	• Licencia de conducción o tarjeta de ID del Department of Transportation • Identificación escolar con foto • Registros escolares, atención diurna o médicos • Identificación militar o tarjeta de dependiente • Otra prueba de identificación aceptable

Importante: Usted debe hacer esto para cada ciudadano de los EE.UU. de su familia que reciba Medicaid.

La elegibilidad no se verá afectada por la raza, credo, color, nacionalidad, edad, discapacidad, creencias políticas, religión o sexo, excepto cuando así lo exija la ley.

Comm. 258(S) (Rev. 3//09)

Verifying Citizenship and Identity, Comm. 258 or Comm. 258(S)

Purpose	*Verifying Citizenship and Identity* is an informational notice about federal Medicaid requirements.
Source	The English version of Comm. 258 is printed in individual sheets. Order supplies from Iowa Prison Industries at Anamosa. The English and Spanish versions are also available on line on the DHS Intranet eForms web page.
Distribution	Attach this notice to Medicaid applications and give it to applicants and members when requested or needed.
Data	The notice includes a web address that customers may use to find phone and fax numbers for vital records offices in each state to help applicants and members born outside of Iowa apply for original birth certificates if they do not have verification of U.S. citizenship.